

5-11-2016

# Health in Hartford: A Community-Based Participatory Research Project Identifying Solutions to Health Inequities

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Identifying Solutions to Health Inequities

Karen A. D'Angelo, Ph.D.  
University of Connecticut, 2016

ABSTRACT

Overall poor health status and unfair, disparate health outcomes for vulnerable population groups are of grave concern in the United States. Rooted in unequal access to and the disparate quality of the social determinants of health, health inequities disproportionately affect people of lower socioeconomic status and people of color. Defined as the willingness of people to intervene for the good of the community and associated with positive health outcomes, collective efficacy has the potential to reduce health inequities for urban Americans. Hartford, Connecticut is one urban city which unduly suffers from health inequities.

Photovoice was the primary methodology used in this qualitative, multistage, longitudinal community-based participatory research (CBPR) study. Photovoice integrates photography, storytelling, and political advocacy. This study aimed to: 1) understand how community members perceive the relationship between place and health in their city; 2) identify participants' recommendations for improving health in Hartford, Connecticut; and 3) assess how the critical consciousness-building process inherent in photovoice affected participants' collective efficacy.

Karen A. D'Angelo - University of Connecticut, 2016

A total of 24 Hartford residents participated in at least one stage of this study; 11 completed all four stages. Findings revealed that participants conceptualized health into three domains—physical wellness, mental and emotional health, and spirituality. Eight themes were identified involving participants' perceptions of the critical factors that affect the health of city residents; these are access to healthy food, access to nature, housing and homelessness, substance abuse, litter, education and role models for young people, community investment, and community engagement. Recommendations to improve health were identified for each theme. Participants' suggestions may be used to develop innovative and practical community interventions; once implemented, these may be evaluated to assess their impact on health.

Findings demonstrated that participants' critical consciousness increased during the photovoice process; however, no changes in their collective efficacy were detected during this study. Methodological constraints posed significant limitations and more robust research is needed to better assess the impact of photovoice on collective efficacy. Implications for professional social work include interprofessional training, specialized education for social workers in community practice, and CBPR methodologies that integrate a human rights framework.

*Keywords:* community-based participatory research, photovoice, critical consciousness, health inequities, social determinants of health, collective efficacy, community practice, public health social work

Health in Hartford:  
A Community-Based Participatory Research Project  
Identifying Solutions to Health Inequities

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A Dissertation  
Submitted in Partial Fulfillment of the  
Requirement for the Degree of  
Doctor of Philosophy  
at the  
University of Connecticut  
2016



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2016

**APPROVAL PAGE**

Doctor of Philosophy Dissertation

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A Community-Based Participatory Research Project

Identifying Solutions to Health Inequities

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## ACKNOWLEDGEMENTS

I am deeply grateful to have had the opportunity to facilitate this research. I imagined this study long before I pursued doctoral education, and this project fulfilled one of my life dreams. Though sometimes grueling, conducting my dissertation was essentially always fun. I am grateful to all those who sparked my passion, and made it possible.

I offer sincere appreciation to my dissertation committee—Scott, Megan, and Rafael. Thank you for your ongoing support, thoughtful feedback, and late-night editing. This dissertation was not conventional, and without your pioneering spirit and trust in me, I would not have had the necessary support to pursue this meaningful work. Your perseverance was equally as important as mine.

I also would like to thank my many mentors for their guidance over the last decade; you model with integrity the values inherent in CBPR and social justice research. HHC staff, thank you for adopting me as one of your own; to the CEHDL team, I carry you with me always. When I am perplexed, I still think to myself, “What would Angie do?” Grace, thank you for your unconditional support and leadership—I look forward to our future collaboration and hope to make you proud. Louise and Kathy, thanks for shaping me as a community organizer, and scholar—I truly grateful to have had the chance to learn from each of you.

I would like to acknowledge UConn School of Social Work and El Instituto, UConn’s Institute of Latina/o, Caribbean, and Latin American Studies, for your gracious financial support of this study. This funding provided for participant incentives and programmatic supplies, including cameras, food for group meetings, and cash acknowledgements, which were essential for the success of this CBPR project. Thanks, too, to the Hispanic Health Council for providing meeting space and for helping to facilitate this research process.

To all of those who volunteered their time and talent to assist with recruitment, data collection, and analyses—thank you! I could not have facilitated this work alone, and your assistance was deeply appreciated by both me and study participants. I extend a special thanks to the HHC IRB and graduate and undergraduate students Jack, Luis, Lauren, Liz, Raquel, and Katie, as well as Jen, a recent PhD graduate.

To my doctoral student colleagues, I value your friendship and partnership, and will always look back on my time at UConn with gratitude and pride. I have learned with and from each of you, and your fervent energy and commitment to rigorous, impactful, social justice research motivate me to also do my best. In the deepest core of my soul, I identify as a social worker, and I am most thankful for the opportunity to work in solidarity with you, as emerging leaders in this profession. Jack, thank you for being my partner in this journey, I will forever be grateful for your enduring friendship—you add meaning and warmth to my life, and to my work.

To my family and friends, thanks for your patience these last five years. It has been a period of significant chaos and transition, and your understanding and support were invaluable. Jason, thank you for always making me laugh, and for accompanying on this wild ride through life. To our Great Danes Bianca and Bailey, your steadfast love was especially treasured—thank you for your loyal devotion. Jill and Sarah, cheers to strong women! And thanks for being my sisters.

To my nieces Natalie, Charlotte, and Lauren, all born during this project—I hope that you too will have the chance to live your dreams, and leave your unique footprints on this vast world. Mom, thank you for passing on to me your love of health science—it has helped to plant and nurture my passion for health equity research. Finally, Dad, thank you for your many gifts—because of your sacrifices, I more deeply appreciate the opportunities I am afforded.

Hartford will always be home. I honor your struggle, resiliency, and character. Thank you to those who participated in this study—your courage and strength are an inspiration, and your stories illuminate the grave inequities faced by urban residents. It has always been my hope that this project will help to improve the well-being of Hartford, and I look forward to the day when all of humanity has the right to health and wellness. ¡Adelante!

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## CHAPTER 1: INTRODUCTION

Since its inception, social work has been dedicated to improving the lives of society's most vulnerable and marginalized citizens. The profession is grounded in a holistic and ecological understanding of human challenges, as both settlement house and charity organization society workers facilitated improved environmental contexts for clients (Richmond, 1917; Wencour & Reisch, 1989). Macro level social work practitioners have since worked on a grassroots, community level to foster community change. Nonetheless, the profession today is struggling to address many complex, social problems rooted at the local level.

Health is one such challenge. In the United States, many socially disadvantaged communities are struggling to stay well. People living in such places disproportionately experience higher rates of illness, disability, and premature death. Often, poor, segregated neighborhoods do not have valuable structural and social supports that facilitate wellbeing and consequently, community residents are sicker, with fewer resources to cope (Gilbert et al., 2015; Hicken, 2015; Williams & Collins, 2001). Social work ethics define a clear social justice and human rights imperative emphasizing the need to deepen our understanding of macro-level interventions to address these inequities (National Association of Social Workers, 2008; United Nations, 1948). Such interventions have the potential to ameliorate health by fostering environmental changes in the communities in which people live. Community-Based Participatory Research (CBPR) offers a unique opportunity for social worker researchers to collaboratively develop and test innovative community interventions that may improve the health and well-being of local residents.

This four-stage, photovoice study explores how a CBPR process may enhance a community's collective efficacy. Collective efficacy is a neighborhood construct that is highly

correlated with health. The study takes place in Hartford, Connecticut, a city grappling with chronic poverty and racism, and their harmful effects on the health of residents. The purpose of this chapter is to provide an overview of health inequities, contextualize health and health inequities in Hartford, Connecticut, and discuss the conceptual and methodological framework of this study.

### **Health Inequities & Social Disadvantage**

Despite being among the wealthiest countries in the world, health inequities plague the United States. Dramatic differences in health status and mortality rates for different population groups permeate U.S. society; in general, people of color fare worse than Whites, as do those with fewer economic resources compared to those with more affluence (Centers for Disease Control and Prevention, 2011; Squires & Blumenthal, 2016). These differences, identified as health inequities, are systematic, avoidable, unfair, and unjust (Whitehead, 1991). Rooted in biased historical and current policies, health inequities are a manifestation of racial and economic oppression.

Moreover, the United States is facing a health crisis: it spends more per capita on healthcare than any other industrialized country, with one of the highest spending growth rates, yet remains far behind on many key health indicators (Braveman, Egerter, & Mockenhaupt, 2011; Henry J. Kaiser Family Foundation, 2011; Organization for Economic Cooperation and Development, 2011). Compared with their counterparts in other high-income countries, Americans at every income bracket have shorter life expectancies and higher rates of illness (Wolf & Aron, 2013). Americans lag behind in nine domains that include: adverse birth outcomes, injuries and homicide, adolescent birth and sexually transmitted infections, HIV/AIDS, drug-related mortality, obesity and diabetes, heart disease, chronic lung disease, and

disability (Wolf & Aron, 2013). Such health disadvantage is rooted in the socio-ecological foundations of health.

Health may best be broadly defined as the “state of complete physical, mental, and social well-being, and not simply the absence of disease” (World Health Organization, 2003b, para. 1). Health is not only the product of individual factors such as genetics, behaviors, and lifestyle choices, but also of root *social* causes that can define a lifelong health trajectory (Robert Wood Johnson Foundation, 2008; World Health Organization, 2008). Health inequities are thus grounded in the social determinants of health. The social determinants of health include “the conditions of daily life in which people are born, grow, live, work and age, which are shaped by the [unequal] distribution of money, power and resources at global, national and local levels” (World Health Organization, 2012, para. 2). The social determinants of health act as mechanisms through which the localized, physical, and social environment affects health. Determined at the community level, the social determinants of health affect local residents’ access to needed services and goods, their ability to participate in healthy behaviors, and their exposure to environmental toxins and stress (Bermúdez-Millán et al., 2011; Williams & Collins, 2001). In order to eliminate health inequities and improve a population’s health, the conditions of daily life must be improved (World Health Organization, 2008); such conditions include but are not limited to access to secure housing, nutritious food, safe neighborhoods, social support, and strong jobs.

Neighborhoods, or people’s “immediate residential environments,” have a particular effect on health; through its influence on the structural social determinants at the neighborhood level, the built environment is especially influential (Diez Roux, 2001, p. 1784). The built environment includes the aspects of the physical milieu that are human made or modified,

including homes, schools, workplaces, highways, and urban sprawl (McNeil Ransom, Greiner, Kochtitzky, & Major, 2011). The built environment influences people's access to valuable resources which may involve exercise, recreation, and healthy food, as well as exposures to environmental toxins such as air, water, and noise pollution (Kumar Pasala, Appa Rao, & Sridhar, 2010). Through its direct impact on mobility and social interactions, the built environment has a direct impact on people's abilities to practice healthy behaviors (Cohen, Finch, Bower, & Sastry, 2006). For example, it would be challenging for a person living in poverty to exercise if the neighborhood in which he/she lives is not conducive to physical activity because of the lack of an inviting area so do so, or simply because it is unsafe. Through zoning regulations and development decisions, choices regarding the built environment are regulated at the local community level. In order to affect policy change, it is therefore important for community residents to not only be conscious stakeholders regarding political and policy matters involving their community's built environment, but also advocates for desired changes.

In addition to structural social determinants, social support also has a significant impact on health. Social support, which is often derived at the local level, provides people with social and practical resources that promote resiliency to stress (Berkman & Syme, 1979; House, Landis, & Umberson, 1988; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). Through a process of mutual aid, social networks help people feel cared for and valued. On the contrary, social isolation and exclusion are inversely related to health on many indicators, including chances of survival after a heart attack, increased rates of depression, greater risks of pregnancy complications, and higher levels of disability from chronic disease (World Health Organization, 2003a). Social isolation is also directly related to increased mortality (Pantell et al., 2013).

Poverty has a damaging influence on health. In contemporary U.S. society, poverty dramatically affects the conditions in which people live: people who experience poverty are often denied access to safe, adequate housing, quality education, transportation, access to healthy foods and adequate health care, and other factors necessary for full participation in life (World Health Organization, 2003a). Poverty also indirectly affects people's stress levels and their ability to cope with stress, both of which significantly influence overall health. Absolute poverty is defined as "a lack of the basic material necessities of life;" those most marginalized in society, such as persons suffering from homelessness or undocumented immigrants, are particularly vulnerable to absolute poverty (World Health Organization, 2003a, p. 16). Conceptually defined as "being much poorer than most people in society" and operationalized as "living on less than 60% of the national median income," relative poverty on the other hand affects a larger proportion of the population (p. 16). With its wide income disparities, the United States struggles greatly with relative poverty. In the late 2000s, the United States had the worst rate of relative poverty in the developed world, with 17.3% of households receiving income below half of household-size-adjusted median income (Gould & Wething, 2012). In the United States, poverty disproportionately impacts people of color, children, families with women as head of household, and people living in urban centers (Institute for Research on Poverty, 2014).

Poverty is often concentrated at the neighborhood level, and concentrated poverty has detrimental effects on the health of community residents. Neighborhoods that suffer from income inequality also tend to suffer disproportionately from less social cohesion and more violent crime, higher rates of coronary heart disease and hypertension, and a higher prevalence of smoking and low birth weight (McGrath, Matthews, & Brady, 2006; Morenoff, 2003; Pollitt et al., 2007; Ross, 2000; Steptoe & Feldman, 2001; World Health Organization, 2003a).

Furthermore, neighborhood conditions in childhood have a profound influence on adult health. For non-Whites, poor neighborhood quality during childhood has strong and significant effects on the proportion of time spent in poor/fair health over the life course. In most cases, the effects of living in impoverished neighborhoods as children are not mitigated by improvements in the neighborhood environment as adults (Vartanian & Houser, 2010).

In addition to concentrated poverty, disinvestment in racially segregated, urban infrastructure has also unduly harmed the health of African Americans and other people of color in the United States. Racial segregation, defined as the “spatial distribution of one racial group relative to another,” is a fundamental cause of health inequities (Brooks Biello, Ickovics, Niccolai, Lin, & Kershaw, 2013, p. 24; Williams & Collins, 2001). Through complex mechanisms of historical and contemporary institutional discrimination and private practices, racial segregation isolates people of color from White communities. As a result, those living in isolated, racially segregated communities are exposed to cumulative social disadvantage (Massey & Denton, 1993). Black/White segregation in metropolitan areas across the United States means that although, in absolute terms, there are more poor Whites than African Americans, poor Whites typically have the advantage of living next to non-poor people in better resourced neighborhoods, while poor Blacks are contained in areas with higher poverty. Sampson and Wilson (1995) concluded that the cruelest urban context in which Whites live is notably more advantageous than the average context of Black communities.

Williams and Mohammed (2009) found that “the most critical determinant of problems linked to segregation is...the concentration of economic and social disadvantage and the absence of an infrastructure that promotes opportunity” (pp. 14-15). The localized, social structures in segregated areas perpetuate a wealth and health gap through under-resourced schools, housing

discrimination, and disinvested physical infrastructure. Williams and Collins (2001) suggested that elimination of racial segregation would lead to the “disappearance of Black-White differences in earnings, high school graduation rates, and idleness, and would reduce racial differences in single-motherhood by two-thirds” (p. 407). Moreover, considering “racial inequities in health status...are predominately the results of place,” and since “race helps to determine place,” racial segregation affects health (LaVeist, Gaskin, & Trujillo, 2011, p. 2).

Residents of racially segregated neighborhoods of color suffer disproportionately from a variety of health conditions (e.g., morbidity and adult and infant mortality) (Williams & Collins, 2001). For example, Brooks Biello and colleagues (2013) examined the role Black/White racial segregation may play in age at first sexual intercourse, an important risk factor for sexually transmitted disease, and teenage pregnancy. Their findings confirm previous research, indicating a pervasive Black/White disparity in age at first sexual intercourse in adolescence; these findings could not be fully explained by individual characteristics suggesting that racial segregation, particularly hyper-segregation, may play a role. In addition to the direct socioeconomic effects of racism on health, Williams and Mohammad (2009) proposed that internalized oppression, employment and housing discrimination, and differential access to quality healthcare services, are also consequences of segregation that are deleterious to health. Furthermore, concentrated poverty and racial segregation imply that in the United States not only are the social conditions in which people live widely disparate, but so are the community and neighborhood processes (Sampson, 2012). Social networks, community norms, and mutual aid may all be impacted by concentrated social disadvantage. For example, recent research by Moskowitz, Vittinghoff, and Schmidt (2013) suggested that poverty may mitigate the benefits of social support on health, so that not everyone living in urban poverty receives the same stress-buffering effects of social

support. Hartford, the capital city of Connecticut, is one community whose residents suffer disproportionately from social disadvantage, racial segregation, and health inequities.

### **Hartford, Connecticut**

Once one of the wealthiest cities in the country, Hartford is today one of the poorest. With a population of 124,775, over 30% of all residents and close to 40% of all families live below the federal poverty line (Hartford Department of Health & Human Services, 2012). In 2014, the median household income in Hartford was about \$29,000, less than half of Connecticut's median household income of just over \$70,000 (Connecticut Voices for Children, 2015). With substantial Latino (42%) and African American populations (37%), Hartford is a relatively young city with 34% of its population under the age of 20, and only 10% age 65 or older. Many Hartford residents trace their lineage back to Puerto Rico (33%) or the West Indies (10%), while a growing number of people are immigrating from Latin America, Eastern Europe, Africa, and Southeast Asia (Hartford Department of Health & Human Services, 2012; U.S. Census Bureau, n.d.a; U.S. Census Bureau, n.d.b).

Though Hartford is racially and ethnically diverse, the city struggles with racial segregation (University of Connecticut Libraries Map and Geographic Information Center, 2012). Clear distinctions exist between census tracts in the proportion of the population that is Black, Latino, and White, with the central part of the city having a larger concentration of people of color. Moreover, as Hartford's ethnic/racial minority populations have dramatically increased since 1950, it has become culturally and socioeconomically distinctive relative to its mostly White, surrounding suburbs. The greater Hartford area struggles with higher levels of racial segregation than most urban areas nationally, which is compounded by concentrated poverty in



places such as the city of Hartford, where residents primarily identify as non-White (Buchanan & Abraham, 2015).

The social conditions in which Hartford residents live dramatically impact their health. In interviews on the quality of life in Hartford with local community stakeholders, over half reported Hartford as ranking “poor” or “very poor” on almost all questions, including poverty (93.1%), job opportunities (87.3%), quality of housing (72.4%), neighborhood safety (71.9%), and schools/education (65.5%) (Hartford Department of Health & Human Services, 2012). City residents struggle with relative poverty, especially considering the stark disparities in wealth between Hartford and other towns in Connecticut, which is among the richest states in the country based on median household income (U.S. Census Bureau, n.d.c.). At the same time, many of the most marginalized residents live in absolute poverty, as many report struggling with basic needs that include housing, health care and food access. According to the Health Equity Index, a tool which correlates local health indicators with social determinants of health, education, economic security, and civic involvement had strong correlations with life expectancy in Hartford; low scores on these indicators related strongly to lower life expectancy in the city compared with the state and the nation (Hartford Department of Health & Human Services, 2012).

Not surprisingly given its concentrated poverty and racial segregation, Hartford struggles with health inequities. The two leading causes of death in Hartford between 2005 and 2010 were heart disease and cancer (Backus & Mueller, 2013; Hartford Department of Health & Human Services, 2012). The age-adjusted mortality rate during those same years was very high, for all causes of death in Hartford (838) in comparison with the average mortality rate in Connecticut and the United States. Indeed, in 2011, Connecticut’s had one of the lowest mortality rates in the

country (660) (Backus & Mueller, 2013; Centers for Disease Control and Prevention, 2014). Moreover, Hartford's infant mortality rate (12.7/1000 live births) is higher than any other city or town in the Connecticut and more than double the state's rate (5.2/1,000 live births) (Fritz, Stone, Mueller, Amadeo, & Backus, 2015). Infectious diseases including HIV and sexually transmitted diseases are also significant concerns for Hartford's population (Hartford Department of Health & Human Services, 2012). In 2011, Hartford had more news cases of chlamydia and gonorrhea than any other Connecticut town (Connecticut Department of Public Health, 2014). Chronic illnesses, including diabetes and asthma, and mental illness are also highly prevalent (Hartford Department of Health & Human Services, 2012). In 2009, Hartford had the highest rate of asthma-related visits to the Emergency Department per its population than any other town in the state; it was 4.7 times the rate for Connecticut (Connecticut Department of Public Health, 2014). Community leaders' perceptions of health parallel the epidemiological data; community leaders identified obesity, diabetes, mental illness, heart disease, and asthma as the most significant health issues facing the city (Hartford Department of Health & Human Services, 2012).

### **Conceptual & Methodological Framework**

Community-based participatory research (CBPR) is a specific type of participatory action research based on an equitable interdependent partnership between academic researchers, community-based researchers, and community members (Kemmis & McTaggart, 2005). CBPR typically attempts to understand how best to ameliorate community problems by drawing upon the grassroots expertise of the community. The research is thus solutions-oriented; its overt goal is to take what Olschansky defines as "constructive action" (2012, p. 306). Israel and colleagues (2003, pp. 49-52) highlight the following nine key principles of CBPR:

CBPR facilitates collaborative, equitable partnerships in all phases of the research; integrates and achieves a balance between research and action for the mutual benefit of all partners; recognizes community as a unit of identity; builds on strengths and resources within the community; promotes co-learning and capacity building among all partners; involves a long-term process and commitment; emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease; disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process; and involves systems development through a cyclical and iterative process.

Rather than conducting research *on* people, CBPR takes a team-based approach of doing research *with* community participants, with the goal of empowering those who are marginalized to confront oppressive systems that contribute to their vulnerability (Olschansky, 2012). CBPR methodology is particularly salient with social work in that it values the primacy of local expertise of community members, and seeks to generate new knowledge for the purpose of social change (Lincoln, Lyndham, & Guba, 2011).

The construct of critical consciousness is central to a CBPR approach. Developed by Brazilian educator and social activist Paulo Freire, critical consciousness allows oppressed people to understand their lived experience in the broader context of structural oppression. Freire developed a consciousness-raising, educational approach that employs structured dialogue to engage participants in a process of critical reflection or conscientization (Freire, 1993). Freire's approach "empowers people to analyze critically, social, political, and economic relations, and to act as community advocates in order to affect policy" (Wang, Burris, & Yue Ping, 1996, p. 1392). Freire argued, "Liberation is a praxis—the action and reflection of men and women upon their world in order transform it" (Freire, 1993, p. 79). Co-learning is emphasized in order to create a jointly understood reality, and teachers are also recognized as learners (Cheatham & Shen, 2003; Wallerstein, Sanchez, & Valarde, 2005). Through Freire's approach, participants come to understand themselves as community advocates, thus

transforming their image as passive recipients of policy decisions, ignorant of social forces, to active actors, engaged in the policy arena (Wang et al., 1996).

Consistent with Freire's concept of co-learning, CBPR promotes shared learning and capacity building among all partners (Israel et al., 2003). Capitalizing on this partnership and the ability to be creative through an iterative process, its goal is to develop innovative, practical, and effective solutions to social problems (Olschansky, 2012). The process of CBPR facilitates the development of insider knowledge that applies only to the community and is otherwise not available to researchers (Kemmis & McTaggart, 2005). Paralleling Freire's empowerment education model, these valuable and unique solutions that evolve out of CBPR stem not only from the knowledge generated as research outcomes, but also through the empowerment process of participants, (Israel et al., 2003). Typically, participants of CBPR are in some way marginalized, and experience one or more forms of oppression. Similarly, drawing on Freire, one of the main tenets of CBPR research is that it "integrates and achieves a balance between research and action for the mutual benefit for all partners" (Israel et al., 2003, p. 56-57).

### **Collective Efficacy**

Expanding on his theory of self-efficacy, Albert Bandura first studied collective efficacy in the organizational context of schools. Bandura (1997) noted "perceived collective efficacy is defined as a group's shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments" (p. 477). In other words, Bandura suggests that collective efficacy may be defined as a group's shared beliefs in their combined power and ability to yield desired goals.

Robert Sampson later operationalized the concept of collective efficacy in his fifteen-year case study of crime in Chicago neighborhoods (Sampson, Raudenbush, & Earls, 1997).

Sampson and colleagues (1997) suggested the following:

Social and organizational characteristics of neighborhoods explain variations in crime rates that are not solely attributable to the aggregated demographic characteristics of individuals. ...The differential ability of neighborhoods to realize the common values of residents and maintain effective social controls is a major source of neighborhood variation in violence. (p. 918)

Collective efficacy is defined as “the process of activating or converting social ties among neighborhood residents in order to achieve collective goals” (Kirk, 2010, p. 2). More generally, it has been described as “the willingness of people to intervene for the good of the community” (Sampson et al., 1997, p. 919).

Collective efficacy builds on two major concepts—social cohesion and shared expectations for social control. Social control is defined as “the capacity of a group to regulate its members according to desired principles” which are shared by the group (Sampson et al., 1997, p. 918). Social control may involve accessing institutional resources, such as the police, but this is not necessary. Informal regulations, which involve shared expectations for collective action among a community, also play an important role in social control. Informal control strategies, such as a willingness to monitor social behavior and intervene on an interpersonal level when expectations are violated, are vital to community processes, as is the community’s ability to extract resources in times of crises (Sampson, 2012).

Collective efficacy compliments social capital, a more broadly used neighborhood construct (Ansari, 2013). Social capital is defined as “those features of social organization, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions” (Putnam et al., as cited in Ansari, 2013, p. 78). The construct is made up of

trust, reciprocity, and collective action, which are embedded in the structural element of social networking. Collective efficacy is similar to social capital in that both involve the concepts of trust, solidarity, and cohesion. The major difference between the two is that different from social network theory, collective efficacy does not include social networking in its definition. In developing the theory of collective efficacy, Sampson (2006) was critical of the close ties among community residents assumed to be necessary in social networking theory, and instead suggested that social control was more important in explaining community processes regarding crime and disorder. Sampson argued that alternatively, close social ties may actually be detrimental to social control.

In his longitudinal study of Chicago neighborhoods, Sampson (2012) hypothesized that collective efficacy helps explain the correlation of environmental structures with rates of violence, more so than the demographic makeup of community residents. Sampson found that collective efficacy varied widely among Chicago neighborhoods. Those with high collective efficacy had lower rates of violence, and collective efficacy helped explain the effect of structural deprivation on rates of violence. Perhaps most alarming was that Sampson found that experiences with poverty predicted lower collective efficacy within the community, thus magnifying and complicating the effects of concentrated disadvantage. Based on Sampson's operationalized construct, collective efficacy has been widely studied in regard to various social problems including street crime, domestic violence, and health (Ahern & Galea, 2011; Browning, 2002; Cohen et al., 2006; Maimon & Browning, 2012; Sampson, 2012).

Recent studies have suggested that collective efficacy is also associated with a variety of positive health outcomes for conditions that cluster at the neighborhood level including premature mortality, cardiovascular disease, overweight and obesity, asthma, birth weight, self-

rated health, heat-wave deaths, and depression (Cohen et al., 2006; Sampson, 2012). Collective efficacy may help to decrease health inequities because neighborhoods with enhanced collective efficacy may also provide more tangible support and have increased political resources that promote healthy environments (Cohen et al., 2006). Community members in such neighborhoods might also be more likely to express disapproval when witnessing unhealthy behavior, and be more likely to advocate for healthy ecological change.

Research has also indicated a linear relationship between the built environment and collective efficacy. Cohen, Inagami, and Finch (2008) sought to understand if collective efficacy causes positive health outcomes, or if it is simply an extraneous variable, with features of the built environment actually laying the foundation for such etiology. Interestingly, the authors found that neighborhood parks were independently and positively associated with collective efficacy and that alcohol outlets were in some cases negatively associated with collective efficacy, while fast food outlets and elementary schools were not linearly related to collective efficacy. This study demonstrated a correlation between fixed physical features of a neighborhood and collective efficacy, and also suggested that some aspects of the environment may be more heavily influenced by other factors. For example, non-neighborhood based schools are less likely to increase neighborhood collective efficacy as are fast food restaurants frequently visited by commuters. The authors emphasized that a lack of evidence in revealing a direct association between environmental fixtures and collective efficacy does not mean that such features do not indirectly affect social processes or health.

Other research suggests that interventions aimed at increasing collective efficacy may help to reduce health inequities (Gerding, 2006). Teig and colleagues' (2009) exploratory study of social processes and community gardens found that community gardens have the potential to

enhance collective efficacy of the neighborhood. Thus “collective efficacy in the garden has the potential to mediate health by encouraging social support and access to resources that are protective against poor health” (p. 1120). They suggested that the collective efficacy built from creating a community garden catalyzes a surge of unanticipated benefits outside of the original context of the garden, leading to the development of informal, supportive alliances, and the development of other healthy norms. Further, a three-year, intervention study of urban youth aimed at increasing self-efficacy and empowerment in regard to healthy behavior found that although the program did not appear to significantly change behavior, it had an important effect on collective efficacy, which in turn may facilitate such behavior change (Berg, Coman, & Schensul, 2009). Similarly, Maimon and Browning (2012), in their study of underage drinking, alcohol sales, and collective efficacy, argued that because collective efficacy interacts with the “behaviorally relevant opportunity structure, ... interventions to reduce underage drinking should be focused on creating public policies that promote neighborhood collective efficacy rather than reduce the presence of alcohol outlets” (p. 988).

### **Study Objectives**

This study explores how a CBPR process may enhance a community’s collective efficacy. This study takes place in Hartford, Connecticut, a city grappling with chronic poverty and racism, and their harmful effects on the health of residents. Photovoice, a type of CBPR methodology, is used to explore the following research questions: 1.) How do community members perceive the relationship between place and health in Hartford, Connecticut? 2.) What recommendations do residents of Hartford have for improving health? 3.) Does the critical consciousness-building process inherent in photovoice research affect participants’ sense of collective efficacy?



## **CHAPTER 2: METHODOLOGY**

Photovoice, a type of qualitative, community-based participatory research (CBPR), was the primary methodology used in this study. Photovoice is a research technique that integrates photography, storytelling, and political advocacy (Wang, 2003). It is also an intervention that empowers participants to become advocates for their own well-being, by reaching, informing, and organizing community members (Ohmer & Owens, 2013). Photovoice is defined as “a process by which people can identify, represent, and enhance their community through a specific photographic technique” (Wang & Burris, 1997, p. 369). Like all CBPR methods, photovoice attempts to balance research with action (Israel, Shulz, Parker, & Becker, 1998). “Facilitated group discussions encourage participants to analyze critically and collectively the social conditions that contribute to and detract from their health status. The pedagogy is problem-based and contextual; the knowledge that emerges is practical and directed toward action” (Wang et al., 1996, p. 1392). The three main goals of photovoice are: “To enable people to record and reflect their community’s strengths and concerns, to promote critical dialogue...about important community issues through small and large group discussion of photographs, and to reach policymakers and others who can be mobilized for change” (Wang, 2003, p. 179).

Photovoice has been used with many marginalized communities, on a variety of topic areas. These include single mothers struggling with food insecurity (Chilton, Rabinowich, Council, & Breaux, 2009); immigrant women who recently migrated to small Canadian cities, less accustomed to new immigrants (Sutherland & Cheng, 2009); young adult women with serious illness (Burles & Thomas, 2012); a community disproportionately affected by poor birth outcomes working to improve maternal, child, and family health (Wang & Pies, 2004); marginalized women as an empowerment process to improve health (Wang, 1999; Wang et al.,

1996); formerly incarcerated women transitioning back to the community (Jarldorn, 2016); urban youth at risk for many health problems (Wang, Morrel-Samuels, Hutchison, Bell, & Pestronk, 2004; Wilson, Minkler, Dasho, Wallerstein, & Martin, 2008); aboriginal people in Australia struggling to receive adequate nutrition (Adams et al., 2012); older African American methadone clients (Rosen, Goodkind, & Smith, 2011); African American adolescents experiencing homelessness (Harley, 2015); and transgender persons access to healthcare (Hussey, 2006). Photovoice allows community members to tell their story in their own voice, which facilitates a deeper understanding of their experience of being marginalized. Then, through group dialogue, participants are able to analyze their personal experience through a critical analysis of their specific condition. It is through this process that participants may identify goals for systemic change, as well as an action plan involving political advocacy.

To reiterate, the three research questions addressed in this exploratory, photovoice study are: How do community members perceive the relationship between place and health in Hartford, Connecticut? What recommendations do residents of Hartford have for improving health? Does the critical consciousness-building process inherent in photovoice research affect participants' sense of collective efficacy? More specifically, the objectives of this study were to:

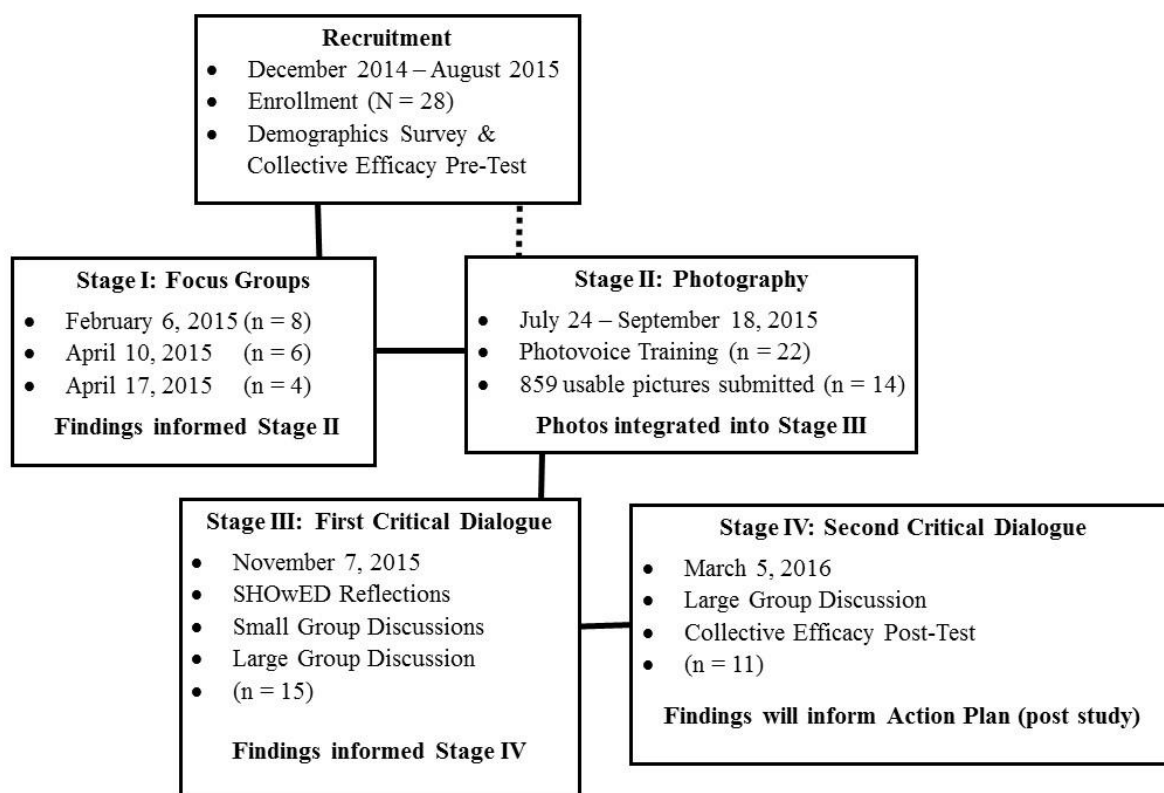
- 1) Elicit Hartford residents' perceptions of their community, including its strengths and challenges;
- 2) Elicit Hartford residents' perceptions of how the community that they live-in impacts their community's health and well-being;
- 3) Promote critical dialogue about issues affecting health in Hartford through small and large group discussion of photographs taken by community residents;
- 4) Identify common concerns among participants regarding health in Hartford;
- 5) Identify priorities for action related to health in Hartford;
- 6) Create a plan for

systems change in the Hartford community; and 7) Assess potential changes in collective efficacy among community members and its role in this social change project.

### Multi-Stage Design

This CBPR study included four stages; each stage was informed by the preceding phases, thus the methodology evolved over time (see Figure 2.1 for a flow chart of study). Stage I involved focus groups, Stage II involved the photography, and Stages III and IV involved critical dialogues. Qualitative data were collected in Stages I, III, and IV, while photographs were collected in Stage II. Quantitative demographic data were collected at the beginning of the study and a standardized measure of collective efficacy was administered prior to participation in qualitative discussions and during Stage IV. The research design evolved in that each subsequent stage incorporated preliminary findings outlined in the previous stage.

*Figure 2.1: Health in Hartford Photovoice Study Flow Chart*



### **Hispanic Health Council**

The Hispanic Health Council (HHC) served as the community partner agency for my dissertation project. Established in 1978, the Hispanic Health Council is a non-profit, community-based organization headquartered in Hartford, Connecticut. Its mission is to improve the health and social well-being of Latinos and other diverse communities, and its four-part strategy involves community-engaged research, evidence-based direct services, policy advocacy, and training for health and human service providers. Unlike most other social service organizations, the Hispanic Health Council was founded as a public health, research organization in response to a community crisis due to language barriers in healthcare. Since its inception, the Hispanic Health Council has facilitated research with marginalized community members with the aim of improving the wellbeing of the community. All of my data were collected on-site at Hispanic Health Council. It provided in-kind support that included space and resource sharing. The research staff supplied consultation regarding methodology and assistance with the dissemination of findings.

I have worked as a research associate at the Hispanic Health Council for the last decade. I was originally hired as part of the Connecticut Center for Eliminating Health Disparities among Latinos (CEHDL). CEHDL was funded by the National Institutes of Health Center on Minority Health and Health Disparities and involved a partnership among University of Connecticut, the Hispanic Health Council, and Hartford Hospital. In my role as research associate, I have worked as part of an interdisciplinary team conducting community engaged qualitative research, program evaluation, and CBPR projects.

### **Institutional Review Board**

The Hispanic Health Council has its own community-based Institutional Review Board (IRB). HHC's Institutional Review Board served as the primary IRB for my study. I also received approval from the University of Connecticut IRB, with the formal agreement that the Hispanic Health Council was the IRB of record. Because of the ethical considerations involved with picture-taking, the study required full-board review. I received initial approval for Stage I of the study. Subsequently, paralleling the evolution across stages of the project, I submitted three additional amendments for Stages II-IV. I met in person with the IRB after the initial submission and after each addendum (twice for Stage II and once for Stages III and IV) in order to answer questions and address concerns.

Participants were given a randomly assigned number. Throughout the study they were referred to by this pseudonym instead of their names. This pseudonym was also used to connect their qualitative and quantitative data. Effort was made to avoid the disclosure of any identifying information during group discussions; in the few occasions when this did happen, this identifying information was removed from the transcript.

### **Why Photovoice?**

I identify as a community practice social worker, and am passionate about social justice issues, particularly those that involve poverty, racism, and health. My primary research interest is in health inequities and the social determinants of health. As a social worker, I envision my role as a facilitator of social change. As a social work researcher, I am most interested in studying processes of social change.

Health inequities in the United States are complex, and longstanding; we need innovative and practical solutions to effectively remedy these social problems. Hence, this is where I see

the utility of CBPR methodology. I am particularly interested in photovoice because it facilitates shared understanding via pictures. Photographs are an artistic medium with the potential to disrupt power differentials between community participants and academic researchers and between the grassroots and policy makers, in a way that is not possible via conventional research (Wang, 1999). I am therefore intrigued by photovoice's potential to enhance mutual understanding and facilitate social change. Furthermore, despite being consistent with our social justice principles, photovoice methodology has been used more commonly by researchers in parallel professions such as public health or education, and has been underexplored in social work (Malloy, 2008)—I am interested in exploring how social work may make unique contributions using this type of CBPR methodology.

Throughout this study, I have attempted to be mindful about my positionality, and aware of power dynamics between the participants and me. As minor ethical dilemmas arose throughout this multi-stage study, and as I made decisions about how to address these considerations, I consciously attempted to be reflexive. In an effort to be transparent about researcher bias and enhance the trustworthiness of this study, I documented my reflections on positionality and ethical considerations via memos. I also used peer debriefing, regularly consulting other CBPR researchers as well as my dissertation committee throughout this process. I will highlight examples of how I practiced reflexivity in making decisions regarding the methodology in Chapter 6 (Discussion).

### **Sampling**

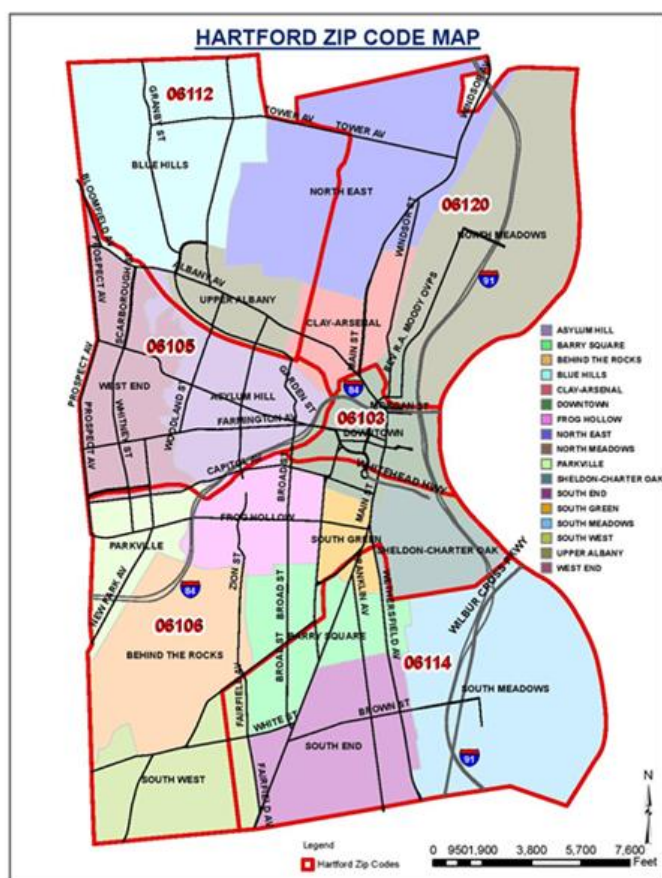
Participants in this study were residents of Hartford, Connecticut. Inclusion criteria required that all participants be adults age 18 or older, residents of the city for at least the last six months, and comfortable speaking English. It is important to note that approximately 35% of

Hartford residents speak a language other than English at home (Hartford Department of Health & Human Services, 2012); thus this language requirement may have excluded a significant percentage of residents from participating in this project, thus limiting its external validity. The reason for this language requirement is due to the fact that photovoice methodology is grounded in small and large group discussion, and to facilitate fluid and clear communication it was important to prioritize a shared language. None of the participants expressed concerns about the study being facilitated in only English; in two instances, two participants felt more comfortable expressing themselves in their first language, Spanish; I encouraged them to say what they were intending to say in Spanish, and I had this portion of the transcription transcribed into English. I am not fluent in Spanish, and thus this was sometimes a limitation when working with participants whose first language is Spanish.

Quota sampling was used at the zip code level in order to ensure a diverse sample. One of the goals of this project is to affect health-related policy in Hartford; considering that the majority of policy decisions happen at the city-level, it was a goal to engage community members who live in every neighborhood. Presumably, in doing so, there is a better likelihood that the priorities identified via this study would resonate with residents across the city and have more representative policy implications. Zip codes were used as proxies for neighborhood (see Figure 2.2 for a map of Hartford zip codes). It has been my experience working in Hartford that there is a perceived divide between what is commonly conceived of the predominantly Latino south end and the primarily Black/African American north end. Interstate 84 physically divides these two parts of the city, and racial tension between these geographical regions is not uncommon. In order to build critical consciousness and collective efficacy across the city, it was important to attempt to bring together residents of different geographic areas. Moreover, in an

attempt to engage community members that may ordinarily be isolated from one another, it was essential to have heterogeneous groups of residents with regards to both race/ethnicity and gender.

Figure 2.2: *Hartford Zip Code Map (Hartford Info, n.d.)*



I originally aimed to include five participants from each zip code in the sample, as well as diversity based on gender and race/ethnicity within each zip code. Of the five participants from each zip code, the goal was to have at least two who identify as male and at least two who identify as female, as well as two who identify as Black or African American, two who identify as Latino/Hispanic, and one who identifies as something other than Black/African American or Latino/Hispanic. Unfortunately, this sampling plan was not feasible because of the considerable



amount of time it took to find these exact quotas thus compromises needed to be made with the sampling plan in order to facilitate the study implementation in a timely manner.

Recruitment began in the late fall of 2014. I developed two versions of a recruitment flyer for the study in English; one version had removable tags listing my contact information that could easily be posted in public settings (see Appendix A: Recruitment Flyer). I identified 21 professional colleagues, all of whom have relationships with the grassroots community in Hartford and know me personally. These colleagues work at non-profit organizations, including the Hispanic Health Council, the local public health department, labor unions, grassroots coalitions, and local universities; several are long-term Hartford residents. I emailed each of these colleagues. The message contained a brief overview of my study and outlined my recruitment criteria; in it, I asked for support with recruitment and requested that they distribute the recruitment flyer to residents who might be interested in participating. I was looking for potential participants who wanted to help improve the community in which they live; thus I asked my professional network to specifically share the recruitment materials with community members that had demonstrated leadership potential. I also announced this study at a HHC staff meeting and requested support with recruitment; I emailed all staff the recruitment materials, and posted flyers in the HHC lobby.

I also emailed 13 chairs/co-chairs of the local Neighborhood Revitalization Zones (NRZs); NRZs are member organizations based in Hartford's neighborhoods. They are part of Hartford 2000, a coalition of 14 NRZs working together to advocate for city neighborhoods. Member NRZs meet regularly; their purpose is to facilitate local community voice in broader decisions affecting the city. While the concept of NRZs is valid, unfortunately community perceptions of these groups tend to be mixed. The leadership of these groups tends to be made

up of people from dominant social identity groups (e.g., White, men), and thus the leadership does not accurately reflect the demographic makeup of neighborhood residents. As a result, community residents are often cautious of the NRZs. Of note, not a single NRZ leader responded to my outreach.

This first phase of outreach facilitated initial recruitment; most participants who joined the study in the winter of 2015 participated in the initial focus group held in February, 2015. Participation from zip code 06106 was initially most robust; this made sense because it is Hartford's largest, residential zip code and it is also the zip code in which the Hispanic Health Council is located. Also, in seven cases, snowball sampling occurred where participants invited their acquaintances to join the study; in five of these cases, these referrals also lived in zip code, 06106. Recruitment then slowed; specific reasons as to why this happened are not clear, however I suspect it was because I had saturated the initial pool of potential participants and needed to increase outreach to penetrate a broader group of Hartford residents. As a result, I expanded my recruitment strategy. I asked community health workers at Hispanic Health Council which places they suggested that I place recruitment flyers in the community. I paid particular attention to places in the zip codes which had minimal representation in the initial sample—06120 and 06112. I posted flyers in 12 community locations that included the city's two Federally Qualified Community Health Centers, 11 branches of the Hartford Public Library, two community centers, and two non-profit human service agencies. I also tried to engage residents in zip code 06103; my graduate student intern emailed the recruitment flyer to her student colleagues living there. Furthermore, I sent emails similar to those earlier sent to my professional contacts to the executive directors of two neighborhood associations in the city, as

well as another seven professional colleagues who have strong community ties but were not included in my initial outreach email.

I also modified my sampling plan. Since I had the most interest from zip code 06106, and since that zip code is both geographically large and highly residential, I allowed more participants to register from that zip code, even after the initial quota of 5 had been met. Previously, before March of 2015, I had created a waiting list in case attrition occurred from zip code 06106; but I realized that this was not fully effective because two participants, when they heard that there were not any openings for zip code 06106, said that they lived in another zip code in order to gain access to the study. This was verified by checking the zip code of their address in order to ensure accuracy, after suspecting that this was the case; address verification however was not a formal piece of this study, as participants' home addresses were not collected in order to protect privacy. Consequently, I removed the zip code restriction from the inclusion criteria which led to more than five participants being enrolled only in zip code 06106.

I was also more flexible with the quotas involving gender and racial/ethnic makeup at the zip code level, as long as each zip code had some diversity on each dimension. Timeliness was a major concern; the longer that it took to finalize the sample, the longer participants were waiting to engage in the study. This waiting time was a risk for early attrition, and thus modifications to the sampling plan were necessary in order to preserve the integrity of the sample. Moreover, I was not successful at recruiting any participants from zip code 06103; this is likely due the fact that this zip code is geographically the smallest in Hartford. It is also downtown, primarily non-residential, and the site of many governmental and office buildings. The homes that are located there include a concentration of luxury apartments, which indicated a higher socioeconomic class which was not represented in this study.

This second major phase of recruitment continued through Stage II—Photography. Originally, I had intended to maintain ongoing recruitment, especially if I needed to account for anticipated attrition. Considering that participants were in smaller groups for Stage I, they did not come together as a complete group until Stage II and did not participate in any qualitative discussions together until Stage III. In overhearing the chatter before the photography training during Stage II, I realized the solidarity participants felt with those who had participated in the same focus group as them. This group cohesion continued to build throughout the last two phases of the study. Thus, I decided to curb recruitment after Stage II in order to protect the group's cohesion, which seemed important to participants' developing sense of critical consciousness and collective efficacy. (See Table 3.1: Health in Hartford Participant List for a complete list of participants.)

## **Data Collection**

### **Research Assistants**

I was the lead researcher for this study and led the facilitation of all data collection. However, since each stage of this study involved complex group processes, it was essential that I had the support of additional research staff. Seven student volunteers (e.g., undergraduates, MSW, and doctoral social work graduate students) acted as research assistants for one or more stages of the study. Through the University of Connecticut, all were certified in social and behavioral research with human subjects, and trained in study protocols. Research assistants helped administer informed consent forms as well as the demographic survey and collective efficacy pre-test. They also assisted with note taking during group discussions and facilitation of small group discussions, and when needed, provided logistical support and assistance with practical considerations (e.g., opening the main door to the locked building for tardy participants;

helping to layout food, disseminating participant incentives, etc.). Three also assisted with transcription of digital recordings, and one helped enter quantitative data into SPSS. After each stage of the study, I also debriefed with each research assistant and incorporated their thoughts into my process of reflexivity. The research assistants provided essential support to this project to ensure a cohesive, efficient, and rigorous research process. As I outline the methodology below, I will make note of tasks completed by the research assistants.

### **Informed Consent**

Before enrolling in the study, each participant was screened to verify eligibility (see Appendix B: Screening Form). Participants were then individually consented to be in the study, and informed of the potentials risks and benefits of their participation. Participants were notified that their participation was voluntary and that they could choose to withdraw from the study at any time. The consent form was reviewed individually with each participant by me or one of the research assistants, and each participant was given the opportunity to ask questions (see Appendix C: Informed Consent Form). All participants signed a consent form regarding their participation in the study, and received a copy of the informed consent form.

### **Demographic Survey**

Prior to qualitative data collection, participants took a demographic survey; its purpose was to be able to describe the sample (see Appendix D: Demographic Survey & Collective Efficacy Pre-Test). It was administered by me, or one of two research assistants. In some cases this was done in the community at a location convenient for them (e.g., their home, a local café), but primarily the survey was conducted at the Hispanic Health Council prior to the date of the scheduled focus group. In a few instances where a pre-meeting was not feasible, it was administered immediately preceding the focus group.

Questions pertained to participants' gender, racial/ethnic identity, socioeconomic status, relationship status, and health insurance status. A single-item measure of participants' self-rated health status was also included. This measure has been used in major U.S. studies and is a strong predictor of mortality (McGee, Liao, Cao, & Cooper, 1999; Wong et al., 2011).

### **Collective Efficacy Scale**

Participants also took a 10-item quantitative, pre/post assessment of collective efficacy developed by Sampson et al. (1997) (see Appendix D: Demographic Survey & Collective Efficacy Pre-Test). Each item was measured by a 5-point Likert scale response, with one being the lowest and five being the highest. This measure has been widely used to measure collective efficacy in health-related studies (Ahern & Galea, 2011; Ahern, Galea, Hubbarde, & Symea, 2009; Cohen et al., 2008; Maimon & Browning, 2012). The purpose of this tool was to provide quantitative data to supplement qualitative findings on collective efficacy.

All participants took the pre-assessment prior to participating in any group process. It was added to the end of the demographic survey, and thus administered by me or the research assistant. Cue cards with visual anchors were used to illustrate the two Likert scale responses used in the questions. Participants in Stage IV took the same measure again after the development of the action plan and prior to discussion about participants' perceptions of collective efficacy; this time the survey was administered in a group format. Cue cards were again provided as a visual reference.

### **Stage I—Focus Groups**

This stage involved three focus groups, which took place on Friday evenings in February and April, 2015. Each focus group lasted approximately 90 minutes and was facilitated by me, using a semi-structured interview guide (see Appendix E: Focus Group Semi-Structured

Interview Guide). Two student researchers provided support during each focus group; one took notes and the other provided critical logistical support. A total of 18 participants took part in one of the three focus groups. The main purpose of these group discussions was to assess participants' perspectives regarding: The places in which they live, how they define health, the strengths and challenges regarding health for people who live in Hartford, Connecticut, and their sense of their neighborhood's social cohesion, trust, and self-regulation. Participants were provided with dinner, as well as a \$10 cash acknowledgment at the end of the group. Participants were also given an updated list of local resources and were told that such resources may be useful to consult if they became distressed about their life circumstances during this study (see Appendix F: Resource List).

After the three focus groups were completed, I conducted preliminary analyses of the data using structural coding of the research assistant's notes from each focus group (Saldaña, 2013). The main objective of these preliminary analyses was to define participants' perceptions of health, and to identify participants' strengths and challenges to living in Hartford as they pertain to health. Notes were used instead of transcripts in order to expedite the process, without necessitating that transcription be complete. The research assistants and I triangulated initial codes. These preliminary findings then helped guide the picture-taking activities in Stage II, and were later expanded upon via formal data analyses.

## **Stage II—Photography**

In July-August, 2015, 22 participants received a 60-minute training on photovoice methodology; 16 participants attended the group training on photovoice, and six participants who could not make the group training, participated in an individual training session with me. (See Appendix G: Photography Training). Seven of the 22 participants had not taken part in the first

stage focus group, so this was their first group process with this study; six of the seven had joined the study after the completion of Stage I. The group training session was held on a Friday evening and participants were provided dinner. The training involved guidance on the use of the camera and photography, ethics of such research, and guidelines for picture-taking (Gant et al., 2009). Participants were advised to be conscious of their safety and the safety of those in the photos, and to avoid taking pictures on private property without permission.

Additionally, as part of the training, participants were reminded about the overall goal of the project—to identify recommendations to improve health in the city. Preliminary data from Stage I were summarized and also presented to participants at the training, in order to guide picture-taking; this included participants' holistic definition of health, and their identified strengths and challenges regarding health in the city. Thus, participants were guided to seek images that they felt related to the health of Hartford residents.

Participants were given double-sided Information Sheets in both English and Spanish that they could use to approach people whom they were interested in photographing; this information sheet helped legitimate the study and the participants' roles as co-researchers (see Appendix H: Information Sheet). Only bilingual, Spanish-speaking participants were encouraged to engage monolingual, Spanish-speaking community members in picture taking. The Information Sheets listed my contact information in case community members had questions about the study. While no community members contacted me with questions or concerns, in one instance this led to a community member becoming aware of and interested in participating in the study; she got my number from the information sheet and called me to enroll in the study. All participants also received training in gaining informed consent of subjects in their photos; if a photo contained the image of one or more people who were identifiable, that person or persons (or if applicable, their



legal guardians) needed to have signed a Photo Consent Form in order for the photo to be used in the study (see Appendix I: Photo Consent Form). These forms were also double-sided in English and Spanish. Participants role-played administering this form with a partner as part of their training.

Before receiving the digital camera, all participants signed a second informed consent form for the study, which outlined the guidelines for picture-taking and noted participants' agreement to follow these protocols (see Appendix J: Photography Informed Consent Form). All participants were given a folder which contained two pens, 25 Information Sheets, 25 Photo Consent Forms, a copy of the Informed Consent Form that they signed for Stage II, and a copy of the PowerPoint presentation which was used throughout the training. Participants were also given a red Nikon Cool Pix L28 digital camera, with batteries and a memory card already inserted, as well as a camera case with two extra batteries. As an incentive, they were allowed to keep the camera if they remained in the study through its completion; otherwise they were expected to return the camera so that another participant might use it. Participants were encouraged to practice using the camera and to ask questions before leaving the training session. Participants were asked to each submit 30, purposeful photos within two weeks. The resource list that was disseminated in Stage I was also made available to all participants (see Appendix F: Resource List).

In order to minimize risk to participants, I developed the Stage II Photography Training and related protocols based on current literature on photovoice methodology and ethics (Community Tool Box, 2014; PhotoVoice, 2009; The Innovation Center & The Kellogg Foundation, 2008; Wang & Redwood-Jones, 2001). Additionally, I sought consultation regarding specific questions regarding photovoice methods and ethics with two members of

external IRBs that are familiar with photovoice methodology, as well as my dissertation committee, one member of which is an experienced CBPR researcher, and the qualitative research coordinator of a national photovoice project. The HHC IRB also provided extensive oversight with the design of this stage of the study. I was especially mindful to maintain an 8<sup>th</sup> grade literary level of written documents in order to help ensure informed consent of the subjects in the photos. This literacy level was important considering that almost one third of Hartford residents age 25 and older have not completed high school (U.S. Census Bureau, n.d.d.). I also had the Spanish translations back-translated into English by at least two people from two different Spanish-speaking countries, and discrepancies were discussed so that the language was agreed upon by both translators.

Out of the 22 participants that took part in the Photography Training and received cameras, 15 returned photos. Only two participants returned pictures within the two-week timeline; within eight weeks, all but one of the 15 had returned photos. This 15<sup>th</sup> participant did not return photos until the First Critical Dialogue; thus, his photos were not able to be printed and were not included in Stage III or IV. Of the seven participants who did not return pictures, four were unreachable due to phone numbers being out of service. One person said that she was unsure what happened to her camera, another person accused a family member of taking it, and another reported having his camera stolen from him on the street while photographing. Also, one participant's camera did not work properly; this person exchanged his camera for one that was operational. While it was inconsistent with agreed upon protocol, no participant returned his/her camera to the study. Though I aimed to get cameras back from those who did not complete Stage II, I had expected that some cameras would not be returned.

When each participant was ready to submit photos, I met with him/her individually and we reviewed the photos together on my laptop. Each participant kept a copy of the pictures he/she took on his/her camera. I copied the entire set of photos onto my laptop. Reviewing the photos, I noted which pictures with identifying people were missing signed Photo Consent Forms. If a person was identifiable in a photo and the participant did not have a signed consent to use his/her picture, the picture was excluded from the study. Each participant and I also attempted to narrow duplicative photos to one; though, in most instances the participants asked that I be the one to choose which photo was the “best” to submit. Furthermore, three participants used the study camera to take photos of personal life events; these personal photos were also removed from my files.

Of the 15 participants who returned photos, only three secured signed Photo Consent forms for the subjects in their photos. One of these participants noted that her study-related documents were mistakenly destroyed by a family member and she requested and received additional blank copies; she re-administered the Photo Consent Forms to the subjects in her photos and later returned signed copies. Several other participants noted that either the people in the pictures did not care about having their photos taken, or that such subjects simply were not interested in signing the forms. One person noted that people in the community were not very friendly and were opposed to being photographed. Likely due to the logistical complexity involved with taking strangers’ pictures, most participants focused on inanimate, environmental subjects in their photos. In developing the methodology, though I realized that it added ethical considerations and complexity, I was hesitant to restrict the picture-taking to exclude other people. I left that decision up to participants and required that they received signed consents.

Due to this extra, required work, it is not surprising that most usable photos did not contain human subjects.

Photos from 14 participants were included for review in the Frist Critical Dialogue. In total, I received 1,221 photos from participants; ironically this is nearly double the 660 pictures I anticipated if all 22 Stage II participants had submitted 30 pictures each. Though I asked for participants to choose approximately 30 distinct photos to share with the study, many took more and a few took less. For example, one participant submitted only 12 photos, while another submitted 241. The mean average of photos submitted from each of these 14 participants was 87.

After receiving the photos from 14 participants, I reviewed all the photos on my laptop a second time, and extracted any remaining duplicative photos from the same participant. The goal was to limit pictures to a manageable number that could be thoughtfully reviewed and processed by participants in Stage III. After reviewing all the photos, I determined 859 were appropriate to be included in the study. As previously noted, most of these photos did not have identifiable people in them and those that did, had Photo Consent Forms signed by the person(s) in the picture or if this subject was a minor, signed by his/her legal guardian; none of these photos were duplicates of the same image. These photos were printed into four by six inch copies. The photos were sorted so that photos from different participants were mixed-up. The photos were then randomly sorted into five separate categories for processing in Stage III.

### **Stage III—First Critical Dialogue**

The third stage, or First Critical Dialogue, was held on a Saturday morning in November, 2015. Participants were invited to attend as long as they had not missed more than one previous stage; thus, even participants who received cameras but did not return photos were invited to the

First Critical Dialogue. Participants were provided with breakfast, and then broken into five small groups of two to three members, primarily based on neighborhood of residence. In two of the small groups, everyone lived in the same zip code, in two of the small groups, participants lived in two different zip codes, and in one small group, participants lived in three distinct zip codes. While the aim was to group participants together from the same zip code, in order to build the critical consciousness of neighborhood residents, compromises were made in order to create balance in the size of each small group.

During Stage III, each small group met in a different space at the Hispanic Health Council, and was facilitated by a different, trained research assistant (see Appendix K: Facilitator's Guide—First Critical Dialogue). Each group was given one of the five stacks of photos to review. Participants were asked to individually look through the photos and choose three to five that stood out to them with regards to health in Hartford. Participants were instructed to not focus solely on the pictures that they may have taken, but to instead simply look at the images and choose pictures notable with regard to the broader objective of ameliorating the health of Hartford residents. Participants were reminded that they were not required to focus solely on challenges depicted in the photos but that they could instead choose pictures that highlighted the strengths of the community.

Participants then took part in individualized free-writes about the pictures that they chose, using the SHOWED mnemonic (Shaffer, 1983, as cited in Wang, 2003) (see Appendix L: SHOWED Mnemonic Free Write.) This tool asks participants to reflect on: *1) What do you SEE here? 2) What's really HAPPENING here? 3) How does this relate to OUR lives? 4) Why does this problem, concern, or strength EXIST? And 5) What can we DO about it?* After completing the free writes, and within their small groups, participants discussed the photos that

they chose and the reasons why they chose them, following the SHOWED mnemonic as a guide. After all members shared and processed the photos, they participated in a nominal group process to decide which photos would be shared in the larger group discussion; their goal was to limit the number of photos that they perceived as most compelling or salient with regards to the health of Hartford residents to between five and eight.

The nominal group process provided a standardized and possibly more equitable way to decide which pictures to prioritize (Van de Ven & Delbeco, 1971). All the photos presented in the small group discussion were listed and numbered, and displayed for all to see. Participants were allowed to review the displayed photos; each participant was informed that he/she may vote for up to three pictures. A formal tally was conducted of the votes for each photo. The five photos with the greatest tallies were the ones that were presented in the larger group discussion; in the case of ties, groups could present up to eight photos. Even with the relatively small group size, this process standardized the group's decision making so that no group member dominated over another, and ensured that all photos were given a fair review.

After a brief break, the five small groups came together as a large group in order to report their findings and begin to identify larger themes pertaining to the entire city. Ground rules to guide group discussion were developed and agreed upon, and study objectives were reviewed in the larger group. Each group then shared the photos they had prioritized with the larger group, along with a summary of the highlights from their small group discussion. Afterwards, participants in the large group discussed what stood out to them most throughout this critical dialogue involving both the small and large group discussions. To conclude, participants were each given \$20 cash as an acknowledgment of their participation, and reminded about the final stage of the project.

Directly after the formal data collection was over, the six research assistants and I met as a group to debrief the First Critical Dialogue. Each small group facilitator also completed a memo noting their personal reflections on their small group discussion (see Appendix M: Small Group Facilitator Memo). We then discussed what went well, and what could have been changed, as well as interesting observations regarding the process and outcomes.

Using open coding (Padgett, 2008), I then conducted preliminary analyses of each small group's flip chart notes, which accompanied their identified photos, and the transcript from the large group discussion, where participants presented a summary of their small group process. This analysis revealed eight key themes, which were supported by participants' quotes and photos. These key themes were the bases of the large group discussion in the Second Critical Dialogue.

Also, in reviewing the photos chosen by each group, I realized that one photo chosen by one group had people in the background who were identifiable. Though the focus of the photo was on two people who were not identifiable, and though the picture was taken outdoors in a public space, I thought it was important to de-identify the people in background, particularly since many of them were youth. Thus, only in this instance, I used digital technology to blur these faces on the copy of the photo that may be publically shared.

#### **Stage IV—Second Critical Dialogue**

Of the 17 participants enrolled in the study after Stage III, 11 participated in Stage IV. I was the lead facilitator of the Second Critical Dialogue; I had support from three research assistants, one acted as a co-facilitator, another as a note taker, and the third provided logistical support (see Appendix N: Facilitator's Guide—Second Critical Dialogue). Once participants arrived for the dialogue, they were invited to peruse the pictures that were identified as priorities

in Stage III and the flip chart notes from each group (see Appendix O: Stage IV Presentation). These were displayed on the walls of the auditorium at the Hispanic Health Council. Participants were asked to consider:

- 1.) What are some of the overarching themes that came up in Stage III?*
- 2.) What points most stood out to you?*
- 3.) What are the most pressing health-related challenges facing Hartford?*
- 4.) What are some of the reasons for these challenges?*

Participants were then reminded of the overall study objectives and ground rules that had been established during the Second Critical Dialogue. The importance of confidentiality was stressed. The list of community resources distributed in Stage I was again given to participants. Participants were also reminded that their participation was completely voluntary, and that the cash acknowledgment that was included as an incentive would only be made available to participants that stayed throughout the entire session.

The eight key themes identified from the preliminary analyses of the data from Stage III were reviewed with participants to verify if this systematization resonated with them, or if they suggested changes. Participants' suggestions were processed and documented. This was a form of member checking to enhance the trustworthiness of the data and strengthen community validity (Ibhakewanlan & McGrath, 2015).

Then, each of the eight themes was presented to participants in more detail, via a PowerPoint presentation; the pictures that were identified for each theme by participants were displayed on the screen and the highlights from the participants' discussion were summarized. Participants were asked to review and reflect on each theme. Participants were asked to brainstorm suggestions about how to improve each concern in order to improve the health and



well-being of Hartford's residents. Notes were documented on flip chart paper, and each suggestion was noted. In the summer of 2016, these suggestions will be used to later draft an action plan for this study which will be disseminated to community stakeholders invested in the health and well-being of Hartford residents.

After a break, participants were next asked to complete the Collective Efficacy Scale Post Test. (See Appendix P: Collective Efficacy Post-Test.) Then as part of the large group discussion, participants were asked to reflect on their sense of collective efficacy in the neighborhoods in which they live. Questions pertained to how much they felt that they could count on their neighbors to do something if a community concern were to arise, and how tight-knit they perceived their communities to be. Finally, participants were also asked to share any changes they perceived throughout this ongoing study, regarding their sense of their neighborhood's closeness and shared capacity to address concerns.

Finally, all Stage IV participants were given the final informed consent form for this study (see Appendix Q: Dissemination Informed Consent Form). This final informed consent form gave each participant the opportunity to choose to disclose his/her identity as related to this study and the picture-taking and data generated through this research project. Participants who chose to disclose their identities in relation to this study were also asked to decide if they would like to be contacted after the study regarding the development of the action plan and/or to help disseminate findings. All participants who wished to be involved with the dissemination of the findings may be invited after the study to co-present the findings to key stakeholders. If a study participant did not sign this final informed consent form, as was consistent with previous protocol, his/her identity in this research project remained confidential. Finally, all participants were invited to contact me to request a copy of the Action Plan which will be available July 1,

2016; a copy will be provided to all participants who request one. Before leaving, participants were given \$20 in cash as an acknowledgment of their contributions to this project. In total, nine of the 11 participants who took part in Stage III elected to disclose their identities as co-authors on study-related reports and presentations; six of which also chose to be part of the formal dissemination team.

### **Participant Engagement & Attrition**

I contacted participants by home phone, cell phone, and/or email; if they had an email address, I used both their email and phone number(s) to reach them, though some never responded to email outreach. I only attempted to contact participants when communication was specifically needed (e.g., to inform participants about the next group meeting, to schedule a time to get pictures back, etc.); In an effort to respect participants' time and privacy, as well as appropriate professional boundaries, I did not reach out to check-in between different stages of the study. However, several participants contacted me to touch base between stages and in these cases, I was responsive. Importantly, participants were asked to contact me if their contact information changed during the duration of the study; this proved to be instrumental to the prolonged engagement of participants, since many reported one or more changes in phone numbers. This is not uncommon in this community seeming that most people use pre-paid cell phones and consequently change their phone numbers often

Three participants also tried to extend the collaboration beyond this study, and suggested working together in other capacities. This was a challenge that was difficult to navigate; while I was mindful to avoid dual roles given my power as the academic researcher on this project, I also wanted to attempt to balance this power differential, especially given that this was a CBPR study. Thus, when possible, I did facilitate professional networking with participants (e.g.,

referring participants to social work colleagues or organizations working on similar goals, such as projects using art for social change). At the same time, I maintained strong personal boundaries (e.g., I did not accept friend requests on Facebook from participants).

The stages of this longitudinal study were spread out over 15 months: Stage I took place in February and April, 2015, Stage II in July 2015, Stage III in November 2015, and Stage IV in March, 2016. Thus, with three to four months between each stage, at each phase of the study, nine participants became lost-to-follow-up; this accounted for the majority of attrition in this study. Many participants used pre-paid cell phones, and often times, once the pre-paid deposit expires, these numbers became disconnected; in each case, unless the participant reached back out to me, due to these logistical complexities, he/she was no longer engaged in the study. In order to attempt to address this, I did ask participants to remind other participants of our upcoming group meetings if they saw each other in the community; because of the sense of group cohesion that developed in this study, this method of outreach was theoretically feasible, though in most instances, these community members still were unreachable.

Of the 28 participants who enrolled in this study, six took part in all four stages. Four of these participants did not take part in any qualitative data; thus their demographic data and scores on the collective efficacy pre-test were removed from quantitative analyses. If a person did not complete more than one stage, then he/she was withdrawn from the study; ten participants were removed from the study for this reason, and most of them were unreachable due to out of date contact information. A total of 11 participants completed the study; a more thorough explanation of participants is provided in Chapter 3 (Sample Description).

### **Data Entry, Analyses, & Storage**

All group discussions (e.g., three focus groups in Stage I, five small group discussions and the large group discussion in Stage III, and the large group discussion in Stage IV) were digitally recorded and transcribed verbatim into Microsoft Word documents. Transcriptions were verified by me for accuracy. Any identifying information that was inadvertently disclosed during the discussion was removed from the typed transcript. Transcripts as well as my research memos were uploaded into QSR NVivo version 10 qualitative software for thematic analyses.

All transcripts were analyzed using the process of open coding (Gibbs, 2007). Primarily, this involved structural coding, and focused on content-based, conceptual phrases relating to the broad research questions. Structural coding is particularly applicable to this study since it involves semi-structured group interviews with multiple participants (Saldaña, 2013). A total of 102 codes were identified.

Thematic analysis was conducted on the list of codes, using the framework (e.g., eight key themes) established from the open coding after Stage III. This framework had been agreed upon by participants as part of a member checking process embedded in Stage IV. Additionally, the theme of collective efficacy was added, and magnitude coding was enlisted to assess the degree to which participants perceived this construct. Magnitude coding is used to indicate the intensity of the code; it is useful in mixed methods research (Saldaña, 2013). This coding allowed for the qualitative data to be compared with the supplemental, quantitative findings.

All quantitative data were entered into SPSS version 21. Frequencies and descriptive statistics were run on demographic variables in order to describe the sample. A Wilcoxon Signed-Ranks test was conducted on the pre/post scores of the Collective Efficacy Scale.

All hard copy data were stored in a locked cabinet at the Hispanic Health Council.

Documents with any identifying information were kept separately from other data. Electronic data were stored on password protected accounts on my UConn personal drive as well as on the HHC server, and my personal laptop. Only I had access to these data.

### **CHAPTER 3: SAMPLE DESCRIPTION**

This chapter provides an overview of participants in this study. Demographic characteristics of participants are summarized. Self-reported identifications of participants' neighborhoods are then reviewed. Self-reported reasons why participants chose to take part in this project are also outlined. In order to address attrition bias, demographic and qualitative comparisons are made between participants who dropped out of the study and those who remained engaged through Stage IV. Finally, brief biographic descriptions of all participants are provided to help contextualize qualitative findings presented in Chapter 4 (Community Perceptions of Health) and Chapter 5 (Collective Efficacy) (see Table 3.2).

#### **Sample**

A total of 28 eligible residents expressed interest in participating in this study; all 28 enrolled. Of these, 24 participants completed one or more stages of this study (see Table 3.1 for a chart of all participants). One woman registered but did not participate in the first or second stage, despite numerous outreach attempts to engage her. Thus, she was withdrawn from the study. Two other women registered but were lost to follow-up almost immediately; their phone numbers were out of service; one of the two provided an email address but never responded to email outreach attempts. After missing two stages of data collection, both of these participants were also withdrawn from the study. A male participant chose to voluntarily withdraw prior to participating because he wanted to focus on personal, entrepreneurial endeavors. Because these four participants did not take part in qualitative data collection, their demographic information and collective efficacy pre-test data were removed from analyses.

Table 3.1 Health in Hartford Participant List

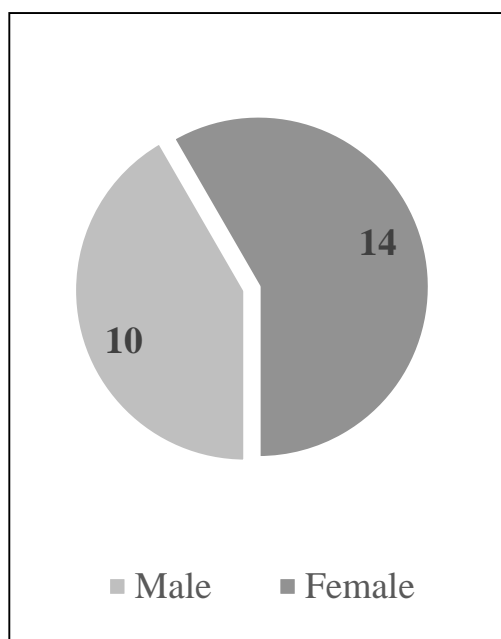
ID	Zip Code	Gender		Race/Ethnicity			Completed Stage			
		Female	Male	Black / African American	Latino / Hispanic	OTHER	1	2	3	4
14	06105		X	X			X		X	
25	06105		X		X		X			
28	06105	X			X		X			
29	06105		X	X						
42	06105	X			X		X	X		
5	06106		X	X			X	X	X	X
13	06106	X		X			X	X	X	
16	06106		X		X		X			
18	06106	X				X		X	X	
20	06106	X				X		X	X	X
26	06106	X		X			X			
27	06106		X		X		X	X	X	X
33	06106		X	X			X			
36	06106	X		X				X	X	X
48	06106	X		X			X	X	X	X
50	06106		X			X	X			
3	06112	X		X				X	X	X
7	06112		X	X			X			
11	06112	X		X			X	X	X	
15	06112		X	X				X	X	X
45	06112	X		X						
17	06114	X		X						
21	06114	X			X		X	X		X
38	06114	X			X		X	X	X	X
46	06114	X			X					
4	06120		X	X			X	X	X	X
10	06120	X		X			X	X	X	X
24	06120	X		X					X	

*Note:* All participants enrolled in the study are listed and grouped by zip code. Demographic identifiers pertaining to quota sampling criteria are marked with an X. Within the Race/Ethnicity categorization, “OTHER” includes participants who identified as White or more than one race. The stages completed by each participant are also marked with an X. Participants who were not eligible to take part in a stage of the study are blacked out. Participants who were eligible to participate in a stage of data collection but did not participate are left blank. Participants 17, 29, 45, and 46 did not take part in the study and thus their demographic data and Collective Efficacy scores were not included in analyses.

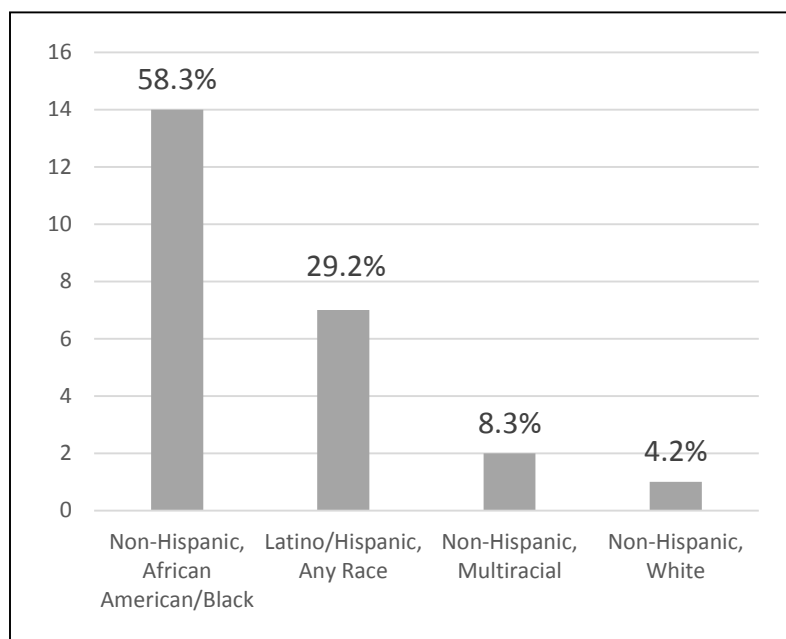
## Demographic Description

Of the 24 participants who participated in one or more phases of this study, all but three (87.5%) were born in the United States. Participants' ages ranged between 21 and 57 years and the mean age was 43.3. Their average length of time living in Hartford ranged from nine months to their whole lives (57 years was the maximum), with a mean of 26.3 years. Fifteen participants (58.3%) reported living more than half of their lives in Hartford, seven (29.2%) of whom reported having lived their entire lives in Hartford. Only six (25%) have lived in the city for less than 20% of their lives.

*Figure 3.1 Gender*



*Figure 3.2 Race & Ethnicity*



In terms of gender, 10 (41.7%) participants identified as male and 14 (58.3%) as female; no one identified as transgender (see Figure 3.1). In terms of race and ethnicity, 14 (58.3%) participants identified as Non-Hispanic, Black/African American; one (4.2%) participant identified as Non-Hispanic, White; two (8.3%) participants identified as more than one race; and



seven (29.2%) participants identified as Hispanic/Latino (see Figure 3.2). Of those who identified as Non-Hispanic, Black/African American, two identified as Caribbean/West Indian and one as African European. The participant who identified as Non-Hispanic, White reported Italian and Polish heritage. One of the two participants who identified as more than one race identified as Black, English, German, and American Indian; the other identified as Black, Italian, and Aboriginal Australian. Of those who identified as Hispanic/Latino, six reported being Puerto Rican and one as “*American*.” Regarding language, 23 participants (95.8%) reported speaking primarily English; only one participant (4.2%) reported speaking both English and Spanish equally as often.

With regard to socioeconomic status, 14 (58.3%) participants reported a household income of \$1,999 per month or less; this would suggest that these households earn less than \$24,000 per year. Five (20.8%) participants reported living alone, nine (37.5%) reported living with one additional person, and 10 (41.7%) reported living in a household with three or more people. At least twelve participants (50%) fell below the federal poverty threshold based on their reported household size and household income; they all reported living alone (U.S. Department of Health & Human Services, 2016). In terms of highest level of schooling obtained, five participants (20.8%) had less than a high school degree; seven (29.2%) completed high school or received a general education diploma; eight (33.3%) had some college experience; one had earned an associate’s degree (4.2%); two (8.3%) had earned a bachelor’s degree; and one (4.2%) had earned a graduate degree. With regards to employment status, seven participants (29.2%) said that they were currently not working or had been laid off; three (12.5%) were working full-time, six (25%) were working part-time (at least one of whom was working multiple part-time

jobs and another was starting a new business), two (8.3%) were students, five (20.8%) were disabled, and one (4.2%) reported his employment status as unspecified “other.”

In terms of relationship status, the majority (15 or 62.5%) were single, never married, and not currently living with a partner. Four participants (16.7%) reported being currently married. Two (8.3%) said that they were widowed and two (8.3%) reported being divorced. One participant (4.2%) noted that she was dating someone.

Six participants (25%) self-rated their health as excellent; nine (37.5%) reported that their health was very good, seven (29.2%) said that their health was good, and two said fair (8.3%). No one reported their health as poor (0%). All but one participant (95.8%) reported having health insurance.

### **Neighborhood Identification**

Participants were asked to self-identify the neighborhoods in which they live. Open-ended responses to this question were coded into the following categories (n=23): “*Hartford*” (n=2); “*North End*” (n=5); “*South End*” (n=5); “*West End*” or “*near West Hartford*” (n=3); “*Frog Hollow*” (n=1), “*Upper Albany*” (n=1); “*North East*” (n=1); *Parkville* (n=3); “*the ghetto*” (n=1); and “*New Britain Avenue*” (n=1). One participant said that she did not know how to identify her neighborhood. Participants’ identification with their defined neighborhood differed, and the delineated boundaries of the city’s 17 neighborhoods did not appear to be salient for most (Live Hartford, 2014). Instead of distinct neighborhoods, participants more commonly associated the northern, southern, and western parts of the city as general regions of Hartford that are different from one another.

Additionally, of the 11 participants who completed Stage IV, all but one reported living in the same zip code as when they enrolled in the study. Participant 36 moved from zip code

06106 to zip code 06103. Anecdotally however, four of the nine participants who became lost-to-follow-up and completed one but not all stages of the study reported in the group discussion, or to me in a one-on-one conversation, that they had recently moved to another neighborhood. This suggests transience among participants within the city, at least for those who dropped out of the study. Additionally, in three identified cases, the neighborhoods that participants described living in during discussions were in different zip codes than the ones that they had reported living in upon enrollment. These conflicting findings question the validity of the zip code as a reliable indicator of neighborhood identification in this study.

### **Reasons for Participating in Study**

Those taking part in this study were interested in contributing to a collective project that aimed to improve the health of their city. When asked via an open-ended question administered as part of the demographics survey, most participants said that they wanted to take part in this project because they wanted to help improve Hartford, their neighborhood, or community; others said that they appreciated participating in this process, and some suggested that they were interested in learning about health (see Table 3.2 for participant responses which are imbedded in participant biographies). One participant mentioned the financial incentive, and another mentioned that they wanted to help support me, the researcher. While the reasons why participants said they wanted to take part in this study varied, all participants in this study generally had a desire to get involved in a social change project, which may distinguish the sample from many other city residents. They may have come to the study with more critical awareness and/or have a stronger orientation to social action than the average person in Hartford.

Those who remained engaged in this project for more than one stage took pride in their role and responsibilities as participants. The financial acknowledgements that were provided helped keep participants engaged. The cash was an important motivator; all but one participant accepted it and some participants requested to receive additional money (e.g., when one person returned her photos she requested payment; another participant asked for extra money for coming to the session early).

At the same time, the financial acknowledgement alone did not seem to be the sole explanation for why participants remained involved. Many discussed the importance of contributing to the project, and many expressed excitement in seeing “what will happen” as the project unfolded. While most participants were not employed, their contributions to this study in some ways served as a substitute for meaningful work. They appreciated being financially compensated for their time and effort and they also valued being part of the larger project that aimed to make a positive impact in their communities.

### **Attrition Bias**

In comparing those participants who completed the study with those who dropped out, there was no difference related to income. Six of the 12 participants who were living below the federally-defined poverty level remained active in the study, while the other half did not. Notably however, the three participants with at least a bachelor’s degree remained active in the study, two of whom also worked full time. Also, the one other participant who was working full time, as well as four of the six participants working part-time, also completed the study. These differences suggest that perhaps those who were more educated as well those who were able to maintain jobs had greater stability in their lives, which may explain why they were able to complete the study.

Furthermore, as previously noted, 11 enrolled participants became lost-to-follow-up due to phones going out of service (two of which were unreachable before participating in group discussions). Qualitative findings reveal that of the nine lost-to-follow-up participants who were active in one or more stages of the study, four reported living in a shelter and moving to another zip code during the study; they described struggling with substance abuse recovery, a recent eviction, and/or prior incarceration and were working to get back on their feet. Three additional lost-to-follow-up participants also reported actively struggling with substance abuse and/or mental illness, one of whom shared the same phone number with an additional, fourth participant who consequently also became lost-to-follow-up. Thus, at least seven of the nine active participants that became lost-to-follow-up were in particularly precarious living situations, thereby suggesting attrition bias. This finding also highlights that the sample included especially vulnerable Hartford residents, who are likely to be marginalized from conventional research.

Table 3.2 provides a brief biographical description of each participant in this study. These bios are provided in order to help contextualize qualitative findings that are discussed in Chapter 4 (Community Perceptions of Health) and Chapter 5 (Collective Efficacy).

*Table 3.2 Participant Biographic Descriptions*

<b>Participant ID #</b>	<b>Biographic Description</b>
3	Participant 3 was a Black/African American woman in her later 50s. She lived in Hartford all of her life and currently resides in zip code 06112. She was the oldest participant and a widow. She took part in Stages II-IV of this study and said that she wanted to participate because it “ <i>sounds very interesting—the health part.</i> ”
4	Participant 4 was a Black/African American man in his middle 40s. He had a Bachelor’s degree. He currently lives in zip code 06120. He moved to Hartford within the last year and thus brought a fresh perspective to group discussions. He took part in all four stages of this project and said that he chose to participate because he is “ <i>concerned of the health of African Americans in urban areas.</i> ”

5	Participant 5 was a Black/African American man, in his later 40s. He has lived in Hartford all of his life and currently resides in zip code 06106. He was working towards starting his own business. He actively participated in group discussions and contributed to all four stages of this study. He said that he chose to take part in this project because it is <i>“something different—something I like to do. Hartford has a lot that they can change.”</i>
7	Participant 7 was a Black/African American man, in his later 30s. He was a college student. He has lived in Hartford most of his life, and currently lives in zip code 06112. He only took part in the first stage of this project. Regarding why he wanted to take part in this study, he said: <i>“I really love Hartford and would love it to get better. And being around positive people.”</i>
10	Participant 10 was a Black/African American woman, in her middle 30s. A life-long resident of the city, she currently lives with her children in zip code 06120. She is a community advocate and is particularly concerned about Hartford’s youth. She took part in all four stages of this study and said that she chose to take participate in order <i>“to help make a change in Hartford CT.”</i>
11	Participant 11 was a Black/African American woman in her later 40s. She has lived in Hartford all of her life and currently lives with her family in zip code 06112. She took part in Stages I through III of this study. She is a leader in her community and passionate about Hartford’s youth. She said that she participated in this project because she is <i>“always interested in helping to find information that can benefit my community.”</i>
13	Participant 13 was a Black/African American woman in her early 40s. She reported living in Hartford most of her life. She is a mother and a student, and is in recovery from addiction. She took part in Stages I through III of this study and was residing in transitional housing in zip code 06106. She said that she wanted to participate in order <i>“to see if something actually gets changed about Hartford. And to learn some things—Hartford is not necessarily bad, like what we hear on the news. Kids get panicky coming into Hartford- bad rap. [There are] positive assets in Hartford too (e.g., Bushnell Park/ ice skating / Fantasia).”</i>
14	Participant 14 was a Black/African American man in his middle 30s. He lived in Hartford for the last six years, having moved from another city in Connecticut. He completed Stages I and III of this study. He was living in zip code 06105 but was displaced during this study. He said that he chose to take part in this project <i>“just to have something to do and see what the outcome is.”</i>
15	Participant 15 was a Black/African American man in his middle 30s. He resided in Hartford for 32 years, and is currently living in zip code 06112. He is a father and a student. He took part in Stages II through IV of the study. He said that he chose to take part in this project because <i>“it’s somewhat intriguing—I saw a flyer, thought it may be something I can do. Also it gives some income; I did a fitness study with UConn before. It’s a chance to make income, and a chance to learn something new.”</i>

16	Participant 16 was a Latino man in his late 40s. He lived in Hartford for four years, having moved with his family from New York. He was a recently retired veteran and struggled with Post-Traumatic Stress Disorder. He completed Stage I of this study. He lives in zip code 06106. Regarding why he chose to take part in this project, he said: <i>“I’m about change. I wanna see my new neighborhood develop. If it needs to change you know. It’s my personal investment.”</i>
18	Participant 18 was a White female in her early 50s. She lived in Hartford for 16 years, and moved with her family from another Connecticut city. She was a widow. She lives in zip code 06106 and is active in her community. She took part in Stages II and III of this study. She said she wanted to participate in this project because: <i>“It would be nice to take pictures and have someone see them and be involved in a group setting. I like doing stuff like this.”</i>
20	Participant 20 was a multi-racial woman in her early 50s. She lived in Hartford for approximately 17 years and previously lived in New York. She took part in Stages II through IV of this study. She currently lives in zip code 06106 and said that she chose to participate in this project in order <i>“to help the neighborhood.”</i>
21	Participant 21 was a Latina in her middle 40s. She has lived in Hartford her whole life; she currently owns a home in zip code 06114, where she lives with her husband and children. She is a teacher and has a graduate degree. She completed Stages I, II, and IV of this study. She said: <i>“I want to participate in this study because it sounds very interesting.”</i>
24	Participant 24 was a Black/African American woman in her early 50s. She lived in Hartford for most of her life and currently lives in zip code 06120. She completed Stage III of this study. She said that she wanted to take part in this project because: <i>“I see so much going on. Somebody needs to speak up. Somebody needs to speak up.”</i>
25	Participant 25 was a Latino man in his middle 30s. He moved to Hartford within the last year as was introduced to the study by Participant 28. Participant 25 completed Stage I of the study, though he did not share much during the group discussion. He said that he wanted to participate in this project <i>“because it is interesting to take part in having an opinion in the community.”</i>
26	Participant 26 was a Black/African American women in her early 50s. She has lived in Hartford for 38 years and currently resides in zip code 06106. She only took part in Stage I of this study. She said that she wanted to take part in this project because she was <i>“very curious about the way things are in Hartford.”</i>
27	Participant 27 was a Latino man in his early 40s. He lived in Hartford his whole life and currently lives in zip code 06106. He is an artist and provides art therapy and education. He took part in Stages I through IV of this study. He said he chose to participate in order to <i>“learn the people’s response to this because it gives me knowledge. When you are involved you are actually communicating and actually uplifting those to do great things.”</i>

28	Participant 28 was a Latina in her middle 40s. She lived in Hartford for the past year, and currently lives in zip code 06105, with her friend, Participant 25. She previously spent a decade of her life in the city. She shared that she struggled with many health problems and rated her health to be “fair.” She completed Stage I of this project. She said that she chose to take part in this project in order to “ <i>put in my input about things.</i> ”
33	Participant 33 was a Black/African American man in his late 40s. He lived in the city for 40 years. He completed Stage I of this project and was currently participating in a transitional housing program in zip code 06106. Regarding why he wanted to take part in this project, he said: “ <i>It’s a lot of things, like I’d like to see the community get more help that they need, more activities for the youth and help the homeless, need more shelters.</i> ”
36	Participant 36 was a Black/African American woman in her early 20s. She was the youngest participant. She lived in Hartford for the past five years and had previously lived in England. She identifies as an artist. She participated in Stages II through IV of this study; during this study she moved from zip code 06106 to zip code 06103. She said that she wanted to take part in this project “ <i>because I have done something like this before with a camera in Hartford. So I can actually make a difference. [I see] broken windows and the trash on ground.</i> ”
38	Participant 38 was a Latina in her early 30s. She has always lived in Hartford and currently owns a home in zip code 06114, which she shares with extended family. She has a Bachelor’s degree and described her health status as “fair.” She took part in Stages I through IV of this study. She said that she chose to participate in order “ <i>to help Karen out, I guess.</i> ”
42	Participant 42 was a Latina in her middle 30s. She lived in Hartford for 75% of her life, including the last 17 years. She resides in zip code 06105 and proudly identifies with the city, describing herself as a “ <i>Hartbeat to the death.</i> ” She completed Stages I and II of this study. Regarding why she wanted to take part in this project she said “ <i>I think I would be a good asset.</i> ”
48	Participant 48 was a Black/African American woman who was in her middle 50s. She eagerly took part in all four stages of this study and demonstrated strong leadership potential. She was a resident of Hartford for 25 years and currently lives with her family in zip code 06106. She said that she wanted to participate in this project because “ <i>I wanna hear what’s going on around Hartford—to hear other people’s news. I’ve never been asked to do something like this.</i> ”
50	Participant 50 was a multiracial man in his later 40s who took part in Stage I of this study. He had lost his job after having been hospitalized and was living in transitional housing in zip code 06106. He was a resident of Hartford for nine years. He said that he chose to take part in this project in order “ <i>to do something good for the community.</i> ”



## CHAPTER 4: COMMUNITY PERCEPTOINS OF HEALTH

This chapter outlines findings regarding participants' conceptualization of health, identification of factors that affect the health of people living in Hartford, Connecticut, and recommendations to improve the health of city residents. As noted in Chapter 2 (Methodology), data from the focus groups, small group dialogues, and large group dialogues (e.g., Stages I, III, and IV) were analyzed using structural coding to identify themes related to health in Hartford. Health is first contextualized from the perspectives of participants and defined by three domains—physical wellness, mental and emotional health, and spirituality. Thematic analysis revealed eight key themes involving participants' perception of critical factors that affect the health of city residents: access to healthy food, access to nature, housing and homelessness, substance abuse, litter, education and role models for young people, community investment, and community engagement. Each theme is presented and photographs that participants' identified as most illustrative of health are used to augment qualitative findings. Participants' recommendations to improve health in the city are also identified for each theme.

### Conceptualization of Health

In the Stage I focus groups, participants were asked to describe how they conceptualize health. They defined health as complex, integrated, and holistic. Many initially described the importance of access to health care for treatment and prevention, but then quickly expanded to other domains. This is well illustrated in the following comment from Participant 38:

*Just thinking about the word "health," it's a lot of different things. It's being able to go to the doctor when you have a stomach ache or when you're not feeling well. Also, going to the doctor to get checked out, your physical, to get preventative services. But health is also having good food to put on the table for your family, having a roof over your head...having a clean neighborhood, not having to worry about looking over your shoulder when you're walking down the street. You know, like mental health. Like going to a church or practicing meditation, like whatever you do to center yourself. That's part of being healthy too. Not just the physical stuff, but also the spiritual kind of stuff.*

*Having good relationships with other people because if you have a bad day and piss somebody off in your family, you know, you're gonna have that weight on you... You're gonna cause yourself stress. I think really it's all tied in. It's a whole big picture. Not just going to a doctor when you feel sick.*

The key components of health included physical wellness, mental and emotional health, and spirituality. However, as outlined in the data, participants' often perceived these factors to be multifaceted, entwined, and mutually reinforcing. Thus, it was somewhat artificial to delineate the findings into distinctly differentiated categories.

### **Physical Wellness**

Physical health was generally understood in the context of health care. Participants highlighted the need to tend to their physical well-being by consulting with medical providers and receiving preventative care and screenings. Participant 33 highlighted the connection between substance abuse and physical health, *“When you get sober, all the symptoms come out. You start feeling aches and pains, and you gotta have your physical done... There's a lot of people that put their health on the back burner. It should be number one.”* He emphasized that substances may also be used to treat physical ailments, and that it may be too late to get effective treatment once a person gets sober and seeks care since the physical illness may have progressed.

Participants stressed that access to quality care is a critical factor for physical health and identified challenges to accessing such care. Some reported experiencing barriers to care due to the lack of availability of necessary services, as Participant 26 reported: *“You know you go to the doctor and the doctor says, ‘We need to see you ASAP,’ [and then says] ‘No, we have a waiting list.’”* Participant 33 highlighted that there are many sick people in need of care, and he stressed the importance of embedding mobile health care services in the community so that care is assessable outside of clinical institutions. Additionally, Participant 13 discussed her experience with Medicaid and not always having adequate coverage for necessary services.

A common concern emerged about the quality of health care that participants have received. Participant 50 stressed that when seeking care from a provider, a patient may have a bad experience that can cause him/her to not want to return. In such cases, this may serve as a disincentive to seek help and instead cause a person to dismiss his/her symptoms in the hope that they will resolve themselves. This delay in care may then have a detrimental effect on a person's health. He shared the following example about one such instance with a provider, where he felt unheard and mistreated:

*The lady was asking me one question four different times in a whole bunch of different ways. [I said,] "Listen, that's not why I'm here. I'm here because of this. And you know, what you gave me before is not working and I'm telling you what worked before you know from another doctor. And you're telling me 'no' and you're not listening...I wanna get some help, and I thought I could come here."*

Feeling unseen or judged by medical providers was commonly reported, particularly in instances where individuals had comorbid physical and behavioral health issues, including substance addictions. Participant 13 noted that providers need to holistically assess patients; she described being prescribed Percocet for dental work, despite this treatment being contradictory to her active recovery for substance abuse. Another individual, Participant 14, felt that he was being profiled as drug seeking for prescription pain medication and stereotyped because of a history with mental illness. He described an example where he needed to be hospitalized for an infection that may have been avoided if his provider had listened to him. In describing his experiences of being labeled by health care providers, he emphasized the need for more patient-centered care:

*It's crazy how these people only see you as what's on a screen. If you went to the hospital one time, say for instance you went to the hospital and went to the mental health ward. Every time you go back to that hospital, that's what they see. Your treatment is based on what's in their system, not what you need. And, that's one thing I've noticed with these hospitals no matter wherever you go. It doesn't matter. You can be on your deathbed. YOU could be on our deathbed and you will have to answer questions while trying not to take your last breath...Why can't you just see people as they are? And*

*that's people, people who have problems, no matter if it's mental, no matter if it's physical. They just have problems. Base your practices on the problem, not on what you see on a screen....And listen to your patients.*

This perspective resonated with other participants who agreed that providers needed a more individualized and holistic approach when providing care. They implied that person-centered care could lead to improved overall health by facilitating access to better quality care.

Some also identified a connection between health and education, with poor health being the result of insufficient education. Participant 7 said, *"I'll just say briefly, health is the reason my mother is no longer living. She died at 43 years old because of health reasons, and lack of education, and...different things. She died because of a health issue called diabetes."*

Participants also perceived that a higher level of education facilitated a higher level of self-efficacy. Education was conceived of broadly and participants emphasized informal ways of learning. Participant 21 noted that she sees health as rooted in the education of the community:

*It's education...It's not only in regards of getting a degree, but it's education in health, education in every form, in every way. How can I help my child? How can I get out of where I am? What is available for me and my family? What can I do? How can we work together?*

Participant 11 emphasized the value of education as a strategy to improve food security through teaching others to grow food. She stated:

*A lot of people are talking about food deserts and food insecurity, and things like that, but there's that old quote, "If you give a person a fish, they'll be able to eat for one day, but if you teach them to fish, they'll be able to eat forever." And this is the same thing with fresh food and gardens.*

Other participants also suggested that community members can be taught how to grow food, thereby implying that such knowledge provides power to improve health.

Several participants also highlighted the importance of food as medicine. Participant 42 said that she manages physical ailments by *"having my food be my medicine versus trying to take*

*a whole bunch of medication, and all that stuff...Just knowing my nutrition, and how that's going to help me physically.*" Participant 7 acknowledged that food is more than a source of energy:

*What you put in your body, you have to be aware of what you're putting in your body. You have to know what the consequences are of what you put in your body, not just because it's tasty. Food has to be looked at as a medicine sometimes too. It's good to eat when you're hungry, but it has to be looked at as a medicine.*

In perceiving food as medicine, there was a general sense of empowerment in choosing food as a source of physical and sometimes emotional healing. Food, several participants suggested, provided a unique sense of control over their well-being.

Additionally, many highlighted the importance of a healthy lifestyle and healthy choices.

Participant 7 underscored:

*We have options, and it's all about either you care...about the choices you're making, or you don't. There's an outcome to everything...there's consequences to what we put in our body. Health is very important to me. It really is.*

Nutrition was also a salient subject. A few participants noted the need to make food preparation part of a "routine" and eating out at restaurants was seen as less healthy, but more convenient.

Participant 16 pointed out the need to prioritize time to prepare food.

*Healthy living is a choice, a lifestyle. It's not just – it's not a happy meal, and let's go. You can't just get up five minutes late to school or five minutes to work and a happy meal will do it. No. It's a way of living. It's a way of adapting. It's setting aside that extra half hour if need be, or more, to make the [food] preparations...*

Participant 11, who disclosed that she struggles with maintaining a healthy weight, emphasized the importance of portion size, describing the modeling provided by her grandmother while she was growing up:

*My grandmother was from the South and she cooked three meals a day and you had a snack in the evening. She was the type – I called her, don't get offended—she gave you—when you look at the food chart and it says, "Two ounces of this, and two ounces of that." My terminology for that is, "White people meals." They ration out the meals. "You not getting no more of this, no more of the greens. You ain't getting two pounds of meat."*

Exercise was also emphasized as an important component of physical wellness, and a couple of participants reported walking to where they need to go as a way to remain healthy. Participant 42 described how she tries to be more physically fit:

*Being active, and just not be in the bed all the time, being lazy, or just watching TV. Trying to go out and stay active. That's a hard one, but just trying to do things a little bit different instead of using the elevator, using the stairs.*

Participant 21 emphasized the need for children to also be active. Participant 42 underscored the importance of preventative health care: “As a woman, when I think of health, I think of my lifestyle, going to the doctor, dentist, [and] eye doctor.” Moreover, sanitation to protect against the spread of bed bugs, personal hygiene, and sterilization of germs were also discussed as elements of a healthy lifestyle. Participant 21 noted that healthy lifestyles are more expensive, as are health insurance coverage and medications, thereby suggesting that *cost* may be a significant obstacle to making healthy choices.

### **Mental & Emotional Health**

Many stressed the importance of mental and emotional health. Participant 11 noted the significance of mental health and its importance in facilitating healthy choices:

*When I think about health, in the streets that I live around today, my mind usually goes more to emotional and mental health. Because I think those are the things that can actually set the landscape for changes in behavior more than anything else.*

Here, she emphasized that healthy lifestyles are undergirded by psychological wellness.

Paralleling participants' perceptions of food as medicine for physical well-being, Participant 16 also emphasized the importance of food in promoting emotional healing. He described using food and tea in order to help manage his anxiety.

*Food heals...I make my own teas, and stuff like that. My way of managing that [PTSD] is with calming foods...like if I'm going to go to sleep. Sometimes I have to do it throughout the day, make my own tea to calm down. I will paint pictures of fruits and vegetables before I eat the fruits and vegetables. It's like a whole routine of things I've learned to have to do since I came back [from active military combat]. Because I'm*

*envisioning my fruit, and the intake, the calories, what it's doing, and I can almost actually see it working through my body. I can't tell a psych that. I can see it. Metaphorically.*

He elaborated that he profits directly from the nutrition provided in food and tea, as well as from meditating on the process of absorbing its benefits. In the previous quote he also pointed out that despite the fact that he found deep personal meaning from this outlook, this perspective is so non-conventional that he would not feel comfortable sharing it with a psychiatric provider.

Those that took part in this study felt that though mental illness was a salient concern, adequate support was not available. Participant 21 said:

*Mental health is a big issue—it's one of the topics that needs to be touched, big time, in our communities because we have all these situations. All these difficulties are happening in our communities, or in our state, and that worries me as a mom.*

Participant 11 responded:

*Especially because they closed down all the places where you go for stuff like that [e.g., psychiatric asylums]. They're out here with us with no resources except for family...If people aren't able to get the help that they need, and then they're out in society, and we love our families. These are our brothers and our sisters, and our uncles, and our cousins, but we can't do anything [to help] them because obviously just because a mother has you, doesn't mean she has the skill set to deal with the mental health issues. So now your dynamics create dynamics for my household, and then I got to go out and interact with people.*

She further emphasized the importance of mental health treatment, and the impact that mental illness has on the family system as well as the broader community. Beyond that, she also highlighted that unresolved mental illness might lead to substance abuse:

*Now you have people that...have a drug issue, but the drug issue really isn't the main problem. That's the after effect. "I choose to get high because I don't know how to deal with this, that." It can be mental health.*

Substance abuse was cited as a major health concern for participants. Participant 28 highlighted how integrated mental health and substance abuse are, yet noted stigma related primarily to substance abuse which hinders adequate support:

*A lot of doctors don't want to prescribe certain medications because you're doing drugs, or you have a mental problem because you're doing drugs. That's the first thing they do justify giving you any kind of help. For example, some people need Social Security, SSI. They're really going through mental health issues. But at the same time, they picked up a habit of either heroin, cocaine, or whatever because they don't know how to cope with their problems. They're not getting the proper medication. So they'll state, "No, well we denied you because you're doing drugs." No, find out the source. The mental health had to come first before the drugs. Then when you're doing the drugs, you get worse in the head because it doesn't balance you. It brings you up and down, up and down. If they get the right medications it can balance the person to be at normal. Is there even such a word as "normal"?*

Notably, seven participants disclosed that they currently struggle with substance abuse or are in recovery; thus this was a pervasive experience among participants.

Fear and stigma surrounding mental illness was also apparent both within and outside of this study. Participant 42 was concerned because her neighbors appear to be mentally ill, which she describes is evidenced by their eccentric dress and esoteric behavior.

*I still don't feel safe. You kind of can see people walking around that might have some kind of mental illness. I only say that because they don't act normal. They don't talk normal. They don't dress normal. Normal is like a pair of slacks, a shirt. This person might have on three or four different shirts. They have five, six, seven different colors on. They might have ornaments in their hair, some really crazy-looking glasses, they don't look right...They almost look like they could be homeless, but you know they're not because they live next door. They're hanging out next door, so you know they have somewhere to go. [They look] very disheveled...just out of it. One day they might be screaming at someone that's not there. The next day they might just be smiling at you. Then the following week, they act like they never even saw you before. It's just staying consistent.*

This perceived odd behavior and unpredictability makes her feel apprehensive in her home.

Furthermore, in disclosing his diagnoses with the group, Participant 16 joked: *"It's no secret—it is a secret. It won't be now. I have a little bit of PTSD. I say a little bit. That's like being a little bit pregnant."* In an attempt to make others more comfortable, he went on to address misperceptions of people with mental illness by explaining that despite his illness, he is a good person trying to contribute to the community; this was a tense moment for the group as others attempted to remain empathetic and supportive.



Participant 16 further reported being diagnosed with Post-Traumatic Stress Disorder after surviving the World Trade Center attack in 2001 and then serving in the military during the U.S. war in Afghanistan. He later went on to more fully describe his experience with mental illness:

*My notions for joining the service wasn't so noble like some other people, like a lot of other people. Mine were sort of vengeful at first. I worked at the World Trade Center when that [attack] happened, and every time I turned the corner, everything was a memory. The people that I used to see every day were not there anymore. The places I used to go into were not there anymore. I couldn't grow. [I moved to Hartford] because I believe I can grow here. My brother lived here for about 10 years. He recommended that I stay with him for a couple days. A couple days turned into a couple weeks. Then I was getting my own place. It's like right now we're all here. Let's say we all went to high school together, all of us. We're having one of those reunions, but 50 more people in this room. Close your eyes. Open them up. They're all gone. You're never going to see them again. What happened? That's the feeling I got every single morning I woke up. Emptiness. I just couldn't grow....*

*...I'm still alive. I've seen some of my friends chose other ways out...I maintain myself in the fight. I continue to be in the fight. I engaged the enemy. The enemy was me, myself, at times. If I am the enemy, then I need to engage myself when I see myself going down a wrong path, and say, "You know what, this is not beneficial for me or anybody around me, for my nephew, for my kids." Then I need to check myself. You know what I'm saying? Then I can start growing.*

This participant described his struggle to remain mentally and emotionally healthy. He pointed out that his need to “grow” is one strategy he employs in order to survive. He contrasted his desire to “grow” and stay connected to humanity with his innate reaction to withdraw and isolate himself from other people.

## **Spirituality**

Many who participated in this study also highlighted the role of spirituality in facilitating health. Some clearly delineated the importance of formal religion and “god.” Participant 27 said, “For me, [the main priority] it's god...because he's the one who gave [health] to us.” Participant 42 explained the role that spirituality plays in maintaining her own mental health:

*Religion plays a huge role for me personally. I can definitely see a difference from when I go to church on Sunday compared to when I don't go to church on Sunday for a couple weeks. I start to act up...It definitely keeps things green for me. I think we're kind of*

*built to believe in something greater than ourselves. There's definitely something else going on that we can't see, that faith can definitely help with. It helps with the mental component and the stress. It helps me feel healthier.*

Several other participants also reported turning to faith and a higher power for support or guidance. Participant 28 noted that she believes that god provides for her well-being, but that she must also work to capitalize on such opportunities. She said:

*God is going to help me, in everything, my health, money, everything...If I don't go out and get it, I'm not going to get nothing. God puts it there, but if you don't do the footwork, you're never going to get it.*

In this way, she saw her well-being as the result of cooperative partnership between herself and “god.”

Some also described the need for solace and peace in describing how spirituality promotes health. Participant 7 described spirituality as follows:

*The body as a whole, the mind, the body, and everything as a whole needs solace, which is peace of mind...It needs a zone to be content, and be comfortable, and be good. The body and the mind yearns for it...As a whole, it [my mind and body] wants that. It wants to have a comfort, a sense of comfort.*

This underscored his belief that spirituality allows him to feel safe and grow.

Several participants also highlighted that they felt empowered helping others, which is another dimension of spirituality. They described health as something that connected them with other people in need of help, and they valued helping others as it provided a connection to something greater than themselves. Participant 27 is an artist and he volunteers his time as an art therapist. He works with people with severe and chronic health conditions who he witnesses struggle to stay motivated and upbeat. He said:

*When I do the therapeutic art, it actually pushes their mind or their thought away from their conditions...and takes away their pain. I try not to focus a lot on the negativity because they are always already thinking about the negativity of their health...And they were like, “You know what? You've really helped me because I'm not thinking about my condition!”*

When he spoke of his work, he said, *“I’m here to uplift them. So for me, health is everything, definitely because a lot of us don’t appreciate it...So I like to give my health. I’m sharing my health with others that don’t have the same health.”* He conceptualized his work to help heal others as in part, a gift of his health.

Similarly, Participant 28 emphasized how she feels empowered by keeping a positive outlook about her health concerns and helping others who may be also struggling to stay well.

*I don’t dwell on my health issues. I just live every day as it comes. I don’t beat myself up [with], “I’m sick. I’ve got cancer.” No. Other people that I know they’re like, “You’re amazing. How can you live like that knowing whatever illnesses you have, and you still have your head up high and you’re strong, and you strive to live longer?” I encourage a lot of people. A lot of people look at me and they were like, “Wow, I don’t know how you do it, but you’re doing it.”...My life has not been perfect at all. But I have things I can teach others. I want to teach substance abuse [recovery], I can do that because I’ve lived that life. I lived a lot of different topics that people use and see in daily life. I’ve lived that. So I always wanted to help kids, because at 15, I started all the stuff that was out there, the streets, the hanging out, not going to school.*

Though struggling with her own medical concerns, she attempted to maintain a positive attitude and share her wisdom to help younger people. Similarly, Participant 16 described how he tries to help other veterans with mental illness:

*Sometimes what they say is the injuries you can’t see are the injuries that are worse. You can see the guy missing an arm or leg. You can empathize, or at least understand. But when you see a person not missing limbs, you’re like, “What excuse does this guy have?” You don’t know. I do advocacy for people who have come back from serving, people who—I call them the wounded but not seen. Many people come back wounded, but unless you see something missing, you don’t think they’re wounded. I do a lot of work with stuff like that, housing, and evictions, and stuff.*

Thus, some participants who reported struggling with health also reported that they enjoy teaching and empowering others like them; in this way, they are able to have an impact on others and be more deeply connected to humanity.

## Eight Key Themes

In Stage III, participants critically reflected on the photos they took and discussed the major strengths and challenges regarding health for Harford residents. Preliminary analyses revealed eight key themes, which were then used to direct the group discussion in Stage IV. These themes are: Access to healthy food, access to nature, housing and homelessness, substance abuse, litter, education and role models for young people, community investment, and community engagement. Participants saw these themes as interrelated as opposed to distinct issues, and in most instances, group discussions surrounding each photograph prioritized in this study integrated more than one theme.

### Access to Healthy Food

Access to healthy food was identified as a pervasive concern among participants. Diabetes was identified as a prevalent health problem rooted in unhealthy diets. Many highlighted that access to reasonably priced, healthy food is a challenge in Hartford,

**Figure 4.1: “Empty”**



due to the lack of grocery stores that sell healthy food at affordable prices (see Figure 4.1).

Participant 11 emphasized that the built environment should provide access to healthy food, and she has witnessed changes in her community over time:

*I think back to how the north end of Hartford looked when I was a kid and a teenager. There weren't corner stores on every corner. There weren't fast food*

*restaurants all over...I have a lot of issues with zoning in Hartford because what comes to our communities.*

Several participants noted that they have to leave Hartford in order to purchase food in surrounding towns.

Several people cited the Hartford Mobile Market as a well-known resource for organic produce that has

helped address the overall lack of access to grocery stores and healthy food.

Community gardens also were identified as assets regarding food access. Several participants reported growing their own food, and most participants reported seeing gardens in neighborhood spaces (see Figure 4.2). Growing food for one's self and family was interpreted to be empowering, and a way of taking control of food access. Participant 24 said:

*I always wanted to learn how to grow a garden, so we can eat it...You can learn how to grow your own food and you know what's in it and it's the best thing to do, survival is the key...What if you don't have no money and something is going on in the world? You need to eat. You could go in your own backyard and then grow your food.*

Additionally, Participant 4 highlighted that community gardens yield “healthier living” as food is available that is fresher, and you know what goes into growing it (see Figure 4.3). Participant 10 also stressed that fresher food tastes better: “You can tell the difference. When you eating onions it's easy to cut, collard greens is real good, it's more, more fresher than going to the store and getting them there.”

**Figure 4.2: “Opportunity to Provide Organic Food at Low Cost”**



Though participants saw community gardens as resources, there was a general lack of familiarity with how to get involved with such projects. The Knox Parks Foundation was one organization identified as a resource by some. Several

**Figure 4.3: “We Are What We Eat”**



suggested that best practices in building community gardens should be developed into educational models for neighborhood dissemination. These should include information about the following: where to grow food, creating collaborations for shared gardens with negotiated roles and responsibilities, nourishing plants, managing pests and rodents, minimizing theft, and distributing produce. Some stressed the need for educational workshops to help residents learn how to grow food. Additionally, participants also suggested innovative programs where produce could be made available to local residents via corner stores, and they proposed that city government donate land to build neighborhood gardens.

The lack of government support for nutritious foods was also identified as a concern. Participant 4 emphasized, *“Government food is not really good for you anyway. White bread, white flour...but it’s what they sell you.”* Several participants agreed, recognizing that *“brown”* is better for health, though less tasty. Participant 10 highlighted the powerful influence of the food industry on food regulation: *“It is basically, controlled by these corporations...who have lots of money to pay for lobbyists, to advocate for [us to] eat more eggs and a few years later eating*



*eggs is bad for you, and things like that.”*

Participants also shared their concerns about genetically modified foods and the use of pesticides in food, and emphasized the need for more federal oversight to regulate the production of food. The quality of food in local schools also was cited as a concern; some highlighted the need for school lunches to be nutritious and for access to junk food to be limited in schools.

### **Access to Nature**

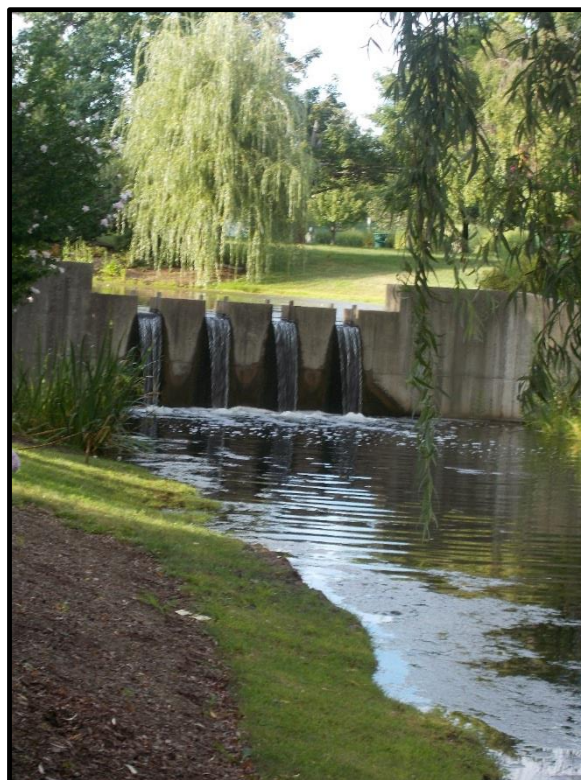
Access to nature and green space was also identified as important for health. A few examples of this were cited: community gardens, local parks, and quiet, outdoor spaces. Access to nature was aligned with a sense of spirituality, described by Participant 7 as a “zone” to find peace, and as a “sanctuary” by Participant 42.

Participant 11 emphasized the value of green spaces:

*I think this is kinda like the foundation for all health. You know, peace within, serenity, and environment. And I believe that as human beings we feed a lot off of our environment and being that, we all know that our bodies are made of mostly water, so water and peace and serenity really impacts our lives and our health.*

Many highlighted the importance of spending time in relaxing, beautiful spaces within the city (see Figure 4.4). Community gardens were valued not only for food access, but because they also offer the opportunity to engage children in multisensory, learning experiences with nature; participants emphasized that though not necessarily intended, gardens and parks may have broad, long-term impacts on the well-being of children (see Figure 4.5). Community parks, too, were

**Figure 4.4: “Teaching Ourselves to Relax”**



**Figure 4.5: “Baby Experiencing Nature”**



appreciated as unique and historical assets; they not only offer places to play and socialize but are also used to host family-friendly events in the summer, including jazz festivals and movie nights.

In order to increase access to nature, most emphasized the need to revitalize community parks. Kinney Park was highlighted as an example of a public space that has deteriorated over the years, with the loss of amenities and a need for better grass in order to, as Participant 3 described, make it “*alive*.” Neighborhood playgrounds were also said to sometimes be unclean and unsafe, thereby suggesting the need for better upkeep by the city.

### **Housing & Homelessness**

Housing and homelessness were shared concerns regarding health in Hartford (see Figure 4.6; it illustrates an isolated, outdoor place where people who are homeless may retreat to in order to rest).

**Figure 4.6: “Speaks of Homelessness”**





Homelessness was seen as an epidemic, due to what some described as “*a broken system.*”

Substance abuse was seen as highly connected to homelessness, and participants stressed the importance of supportive housing services. Participant 15 emphasized that the safety of housing is also a concern: “*If you can even get housing, it’s going to be in a building that is not up-to-code, it has roaches, rats, all of these other issues...the violence that surrounds it, there is a whole plethora of other issues.*” Fires were identified as a risk in housing structures that fail to meet regulations.

Participants identified the irony between the glut of ugly, dilapidated, abandoned buildings in many parts of Hartford and pervasive homelessness; some saw these vacant structures as opportunities to create affordable housing units that might include apartments, shelters, and/or “*boarding houses*” (see Figure 4.7). The suggestion to repurpose unused space expanded beyond old buildings and included developing currently unattractive, sparse outdoor fields as well (see Figure 4.12).

**Figure 4.7: “Abandoned”**

Participant 14 said, “*The unused space around Hartford. There is so much space for, for so many useful things—you can build another shelter, or some affordable housing...to eradicate the homelessness in the city.*” Participant 3



questioned the ethics of decisions regarding the use of empty buildings in the context of this housing crisis. “*They talk about little subsidized housing. If they fixed them up...maybe*

*everybody would have somewhere to go...They're willing to make a store out of an apartment. That's wrong."* Participants emphasized that the newly renovated women's shelter, My Sister's Place, was an important resource for women and children, and Open Hearth, a housing assistance organization, was a valuable support for men. Several people noted that the city needs more shelters and more programs that provide temporary housing for single fathers and their children.

Overwhelmingly, most identified housing affordability as a major and complex concern. Participant 11 highlighted how the Section 8 housing voucher program offers her housing stability, but at the same time may undermine the affordability of housing in the city. Reflecting on the housing crisis in her community she said:

*I'm looking at all of these buildings and I'm trying to grapple, you know, why, you know, we can't keep families housed and one of the reasons that I came up with is because I'm not very far from people that are homeless. [laughs] The only thing that I found over the past few years that separates me from them is that I have Section 8, and I honestly think that Section 8 actually hurt us more than it helped us. Because if it wasn't for Section 8, my girlfriend or the young lady that I am working with would probably be able to afford a house because Section 8 raises the rents...everybody's looking for Section 8...[but] the person who needs a three bedroom apartment doesn't make that type of salary from their job.*

She further introduced complexities regarding the effectiveness of current policies to ensure affordability of housing, and also highlighted how exorbitant housing costs leads to transience:

*In the work that I do, I encounter a lot of young women and older with children who move every three to four months because by the time your landlord finds out that you really can't afford it you're being evicted and eviction can take place within three months; by six months you are moving and then all while you're moving, your children are moving from school.*

Such transience, she emphasized, affects the stability and well-being of the entire family.

## **Substance Abuse**

Drugs and alcohol were also identified as challenges related to mental and emotional health, as well as physical well-being. Evidence of its ubiquity, substance abuse was integrated

into most every other theme in this study. Several reported actively working towards recovery with the support of treatment programs. Participant 13 described sobriety as an ongoing war: *“You’ve gotta prayer up, like put on the whole armor before you leave the house, because it’s like you’re faced with a battle every day.”* Additionally, Participant 27 described how substance abuse is connected to a sense of enjoyment and detracts from more profound engagement with the community and motivation to take part in more meaningful activities.

*[By] partying and giving into these toxic, poisonous, liquids...rather than focusing on what’s the community has to offer because a lot of the time we have a lot of stuff here in the community of Hartford but having fun overpowers...the ambition to do something for the community.*

**Figure 4.8: “Nasty”**



Many saw substance abuse as a coping strategy for survival that was particularly enticing, but at the same time, detracted from broader wellness.

Additional concerns regarding alcohol and drugs included the messages sent to young people. Referring to

paraphernalia found as litter on the streets (see Figure 4.8), Participant 13 noted, *“We can say here and tell our children not to do certain things...but in Hartford when you see this it makes it look nasty. I just figured how the kids must feel...just seeing that every day.”* Moreover,

Participant 3 highlighted:

*With all the package stores, all over the place, it’s like a message to some of the youth, it’s okay. Especially if you find that the children are coming out of broken homes, you know they are more likely to become addicted to something...It’s really sad, the way advertisements is out here for them.*

Participant 27 also highlighted that in an effort to remain “chill” and to connect with their children, some parents drink and/or use marijuana with their children, to the point where such behavior is normalized. He disapproved of this parenting strategy.

Some described drug activity in the neighborhoods as normal, yet problematic.

Participant 27 highlighted a symbiotic relationship with people selling and purchasing illegal drugs on his street:

*They do it very smooth, though. And, what I mean by smooth is that they don't hang out. They go and get what they need in a car, and they bounce...There's a lot happening now more than ever, actually. We've been there for 20 years. Yeah, a lot of drug activity is happening there. Everybody still respects each other. You know, they see us coming...so it's not like it's out of hand, but you know anything is possible. Anything is unexpected. Life is what it is. I respect them. They respect me, and sometimes I get treated better than the people who don't do drugs when they come in. When you see them, they want to help you out. So they're just more and more open.*

His tolerance of this activity is moderated by the respect he feels from dealers, though he infers that it is not necessarily safe. Participant 11 described a similar perception regarding the covert nature of drug activity in her neighborhood: *“There's a lot of drug activity. But it's not overt. It's really not overt. But when I first moved there two years ago, it was more overt.”*

Furthermore, Participant 16 described people using drugs openly in the hallway of his apartment, though they do not live there: *“I've seen people set up living rooms on my staircase, and the porch in the back with a little table, ashtray. It's set up like that. It's got the needle there.”*

Participant 5 described the area in which he lives as “drug-infested” and emphasized that consistent drug activity is the neighborhood’s “only problem.” Participant 33 explained how easy it can sometimes be for some people to fall into the trap of selling drugs; he stressed that generally people are well intentioned and even when they know better, sometimes people make compromises that they may otherwise not choose to make in order to survive. Alternatively,

Participant 13 highlighted the challenges of maintaining sobriety while living in a neighborhood where drug activity is prevalent, particularly at night:

*When I get on the city bus tonight, it's gonna be a project. By the time I get to the Avenue, I'm stressed out. I am by the time I jump off the bus and then run through Garden Street because I can't walk and cruise. I gotta run and make sure I'm in the building safe because it's chaos after it goes down at night. The sun goes down and over there is off the hook.*

Juxtaposed against the discussion on drugs was recognition about the need for good jobs for community residents. When he identified his greatest concerns about the city, Participant 4 said, *"Drugs, I would say. Drugs basically. Probably jobs too."* Beyond simply identifying the problem, Participant 42 provided a deeper analysis:

*The money, money, money, money. It's like where are the jobs? If people are on drugs, and they're out there, and they're acting up, and they're acting crazy, it's because they don't have anything productive to do. Where are these programs that are helping the people? If they're in our neighborhoods, why aren't they more pronounced?*

Figure 4.9 depicts a street corner where community members are simply hanging out, and are seemingly unemployed; alcohol advertisements are shown posted on the corner store, thus contextualizing joblessness with

**Figure 4.9: "Lack of Ambition"**



alcoholism. As Participants 10 and 20 summarized: *"Richest state but the poorest city"* and *"All we have is drugs and police."*

Programs to support people in recovery were seen as invaluable. Several people reported currently taking part in an integrative program that provides support services, housing, and substance abuse treatment, and others shared that they previously had done the same. Participants 13 and 50 saw the sacrifices that they make in order to succeed in such programs as necessary steps towards their ultimate goal of self-sufficiency, and they described their experiences with making such sacrifices as empowering.

Participant 13, however, highlighted the irony of where these treatment programs are located; she and other participants described the challenge of remaining focused on sobriety amidst communities struggling with substance abuse:

*I noticed like every program, if it's a drug program that you go to, it's always in the hood. Always in the main stream of drugs. [She describes treatment programs she took part in that were based in other urban areas of Connecticut.] So it's like you have the mindset to stay sober, but I noticed all these sober houses are like in the middle of the drugs.*

Thus the urban location of such programs may not promote sobriety.

Participants emphasized the value of health care and social services for those in recovery and those still struggling with substance abuse. They stressed the need to reduce stigma surrounding substance abuse among professionals. And, they noted that active substance abuse should not be a valid reason to exclude people from needed resources or services (e.g., Social Security Disability, housing, etc.). In fact, participants saw such supports as necessary in order to treat underlying mental illness in which substance abuse is often rooted.

Many also suggested that laws be changed to restrict the number of liquor stores in the city, as well as reduce the number of hours such establishments are open. Participant 4 drew a parallel to reductions in smoking advertising and suggested that a similar campaign be implemented to reduce ads for alcohol. Some also believed that marketing for alcohol not be allowed at family-friendly places or events. Graffiti, as long as it is sanctioned by property

owners, was suggested as an artistic vehicle for delivering positive, health-related messages to the community. Job opportunities and well utilized, community programming for residents were also said to be needed in order to facilitate employment and productivity.

## **Litter**

Litter was identified as a major, health-related concern that is commonly found in Hartford. A general consensus was that litter is a health hazard; examples included its danger for children who may unknowingly put trash in their mouths, its impact on air quality, and bedbugs, which may be both embarrassing and a health risk. Additionally, Participant 13 described the litter problem to be overwhelming and “*depressing*,” thereby emphasizing its impact on mental well-being.

Some participants connected excess garbage on the street to the larger, structural issue of a recently closed landfill. Participant 4 noted:

*There is a lot of garbage. A lot of waste. Most of the stuff goes in dumps. It's not recycled or anything, and basically [deposited] close to our neighborhood. You don't see garbage disposals, dumps, or waste centers you know, in West Hartford or the west side of Harford. Where I live...there are big mountains, I call it “Mount Trashmore,” near the north end. And I feel like it affects your health in a lot of ways, with toxic chemicals, I hear used to catch on fire all the time...All this excess garbage, they just dump it all, near our neighborhoods.*

Participant 11 also highlighted the significance of Hartford's landfill:

*Nobody can walk past something like this and say this doesn't impact or affect our health. The landfill that they got rid of a few a couple of years ago...before that, it was proven that that landfill caused a lot of our children in Hartford, especially north Hartford, where it was located, to have high rates of asthma....so we know that trash directly relates to our health. And, when I look at things like this or when people from outside that I hear at community forums, they usually blame it totally on the residents.*

Thus, several identified that larger policy decisions regarding trash also affect health, and have implications regarding trash in local neighborhoods.



Some people also emphasized the need for more personal responsibility to ensure the proper disposal of trash. Even with better systems for garbage removal, Participant 15 recognized that litter still persists:

*There's a lot more garbages then there were. They have the big compactors now, there was a conscious effort put out there but it hasn't changed per se. And if you notice where is it at, in the inner cities? If you go out to the towns, and suburbs, you don't see all that. You don't see a bunch of trash, people care about where they live. They are going to go pick up garbage even if it was their own or somebody else's. It's a mentality.*

Thus, several identified behavioral change as an important component as well. For example, Participant 13 reflected on how she struggles to be more personally responsible with trash, “*I used to love throwing stuff out of the window. I was so good for that. Every little thing is a learning process. I'm just trying to do things the right way...If I can help the situation, help it.*”

In order to help control litter, some people suggested that trash collection systems need to be improved: trash bins need to be larger, trash pick-up may need to occur more often, and/or public works programs such as mattress removal need to be more visible (see Figures 4.10 & 4.11). They also emphasized the need for more landlord accountability to help control litter, including government regulation of the disposal of bedbug infected furniture and better access to free or low-cost pick up of bulk items. Many stressed the need to more widely disseminate information regarding government sponsored collection programs, including contact information for city offices and advertisement of cleanup

**Figure 4.10: “#CleanHartford”**





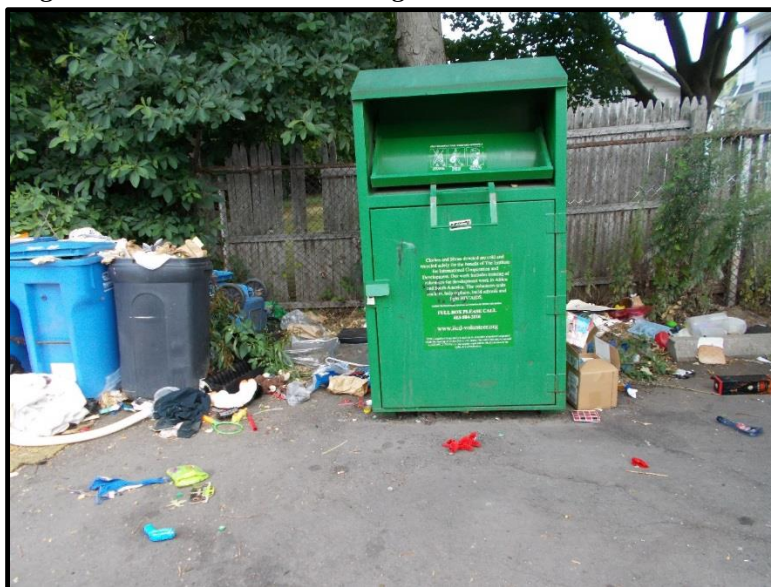
days. Participants also suggested that perhaps some items that would ordinarily be trash could be used for art and/or educational projects with Hartford youth and adults.

## Community Investment

### Community

investment was viewed as essential for the well-being of Hartford and the people who live there. Empty, overgrown lots were thought to be too common; they were seen as lost opportunities for productive use of public space (see Figure 4.12). Strengths in the community involved space that was well utilized and benefited local residents. In discussing the potential of revamping an abandoned apartment building, Participant 36 emphasized, “*It’s an example of construction that*

**Figure 4.11: “It’s a moral thing.”**



**Figure 4.12: “Lost Potential”**



*would add value to the community of Hartford and the reason why Hartford is devalued—there’s tons of building like this all around the community.”* Stark distinctions were emphasized between areas that were recently renovated and those that needed attention.

Landlord accountability was highlighted as important also, as participants perceived that too often property owners are absent and irresponsible with the upkeep of their properties. Some saw the revitalization of the area around My Sister's Place, a housing program in

**Figure 4.13: "Double Plus"**



the north end of Hartford, as having multiple benefits because it involved investment in the road infrastructure, as well as the addition of the new shelter (see Figure 4.13).

Many people were energized about new development happening in the city. The recently constructed Connecticut Science Center was seen as an asset because it promotes learning and brings people to Hartford. However, the new minor league ballpark for the Hartford Yard Goats, which is currently under construction, received mixed reviews (see Figure 4.14). Participant 18 was optimistic about the new venture:

*We have our financial growth, which is a great thing. We have our new attraction, the, um, the Yard Goats and this is a picture of the construction of the Yard Goats and it's behind the fence and we are seeing it getting built up and built up a little more each day, which is great. It's going to be a new attraction for our city and others surrounding. And it's good for tourism, it's gonna be good for a lot of traffic into the city, and we are hoping that it gentrifies the neighborhood, and not just that one thing. We are hoping that they build up around there.*

Conversely, some expressed mistrust about this development. Participant 27 questioned the substantial cost of the stadium and suggested that the money used to finance it could have been spent in more meaningful ways (e.g., programs for youth, well-paid jobs). Participant 4 noted:



*But integration is happening in another way because White people need spaces. They need apartments, affordable housing. If you go to New York for instance in the neighborhoods that were once Black, like Harlem and Bed-Stuy, and they are all White now. And it's going to happen in Hartford...when they build the stadium and stuff like that.*

Most were concerned that development and gentrification may displace current residents from their homes. Additionally, Participant 10 emphasized mistrust over what she fears are empty promises from City Council members to provide jobs to city residents at the new stadium.

Further, Participant 15 questioned the broader economic impact this investment will have on city residents: *"It's going to bring revenue. But...where is that money going to go to? It's not really going to trickle down into the community as much as we would like."*

**Figure 4.14: "Who's Attending the Game?"**



Participants emphasized that investment needs to happen in ways that benefits the people who live in Hartford, rather than as a means of simply attracting those from outside the city. One repeatedly cited example of community investment involved revamping abandoned apartment

buildings into affordable housing units. Many suggested that these buildings could also be transformed into greenhouses to facilitate urban gardening and access to healthy food. Several participants also stressed the importance of ensuring that Hartford residents are able to access the benefits of community investments, such as the Connecticut Science Center and new baseball stadium. Programs need to be implemented to provide Hartford residents free or affordable access to these recreational facilities.

## Education & Role Models for Young People

Educational opportunities and role models for young people emerged as additional priorities related to health. The well-being of children repeatedly came up in the context of other discussions, including but not limited to housing, food access, and substance abuse. Parker Memorial Community Center was highlighted as a valuable resource that promotes learning; it was noted as a safe place for families to visit, and a site for youth to hang out and stay off the street (see Figure 4.15).

**Figure 4.15: “Only Center Still Standing”**



Engaging, hands-on, educational activities for youth were highlighted as vitally important as well. Participant 21 emphasized that small things make a big difference, such as the learning experience a baby had while in the garden (see Figure 4.5). Figure 4.16 depicts a group of young people witnessing two men boxing. Several participants highlighted that the admiration and respect these children have accentuates the potential that adults play as role models for young people. Participant 38 questioned, “*Maybe they [e.g., the children] are wondering that maybe they can do the same as them [e.g., the men].?*”

Hartford schools were also of interest to several mothers in this study. Participants 21 and 10 reported deeply valuing their children’s schools, and were proud of the opportunities that

**Figure 4.16: “Role Models”**



they provide. Participant 10's four children went to Clark School, a community school with built-in supports, which was closed after cancer-causing PCBs were found contaminating the air.

These mothers also had suggestions for how to improve Hartford schools. They each emphasized the importance for educators to know the experiences and culture of Hartford families. They expressed particular concern with young teachers who are not from the city and may be ignorant to the challenges

confronting Hartford youth. Participant 11 discussed concerns regarding classroom size; she also highlighted that special training is needed for Hartford educators:

*To be a teacher today, especially in Hartford, you need probably a social service degree. You need the teacher certification. You probably need to have a pre-med and doctor of something to deal with all of the dynamics. It really ties right back to health. What do our children deal with in the homes? Especially if you're living beneath the poverty level, what do they see when they go out their door every day? What's it impacting?*

Further, she stressed that it is unfair to simply blame educators when Hartford teachers need assistance and schools need infrastructure so that they may be able to effectively support Hartford students. Additionally, several participants suggested that those working with youth should have humility in learning from children; challenges are opportunities for everyone to learn and grow and communication is vitally important, they noted.

Moreover, several mothers in this study reportedly did not graduate from high school, though all the mothers in the sample stressed the importance of education for their children.

Parental engagement in schools was seen as a challenge, as described by Participant 21:

*It's the situation of the parents educating themselves to being really part of the school system, learning. There's parents that just drop their kids. Their boxes, the mail, all the stuff—they don't read what's happening. They don't go to anything. They don't even help the kids to do their homework. That's the education that we have to help.*

Participant 10, who is an active parent in her children's school, also noted:

*I'm always going to keep a positive vision. If all the parents get together, there could be baseball leagues, basketball teams, drill teams, [and] double-Dutch teams. We can be organizing this for our own minority....I hope to see it one day. But the pride—we need a big accountability with the parents, especially in that school system.*

Moreover, Participant 27 highlighted that some parents use foul language when communicating with their children, thereby setting a tone of disrespect that may haunt the child later in school, and again suggesting the need for more parental education. Pressures involving time priorities and the necessity to sometimes work multiple jobs were identified as barriers to parental engagement with their children's schooling.

Many participants stressed the need for well-funded, sustainable youth programming that integrates paid staff. As Participant 27 suggested, “*You have inspired people...but sometimes, the volunteers...they volunteer like a year, two years, but still not getting [paid], but they need to live.*” Additionally, many requested more youth centers, like Parker Memorial, based in more neighborhoods throughout the city; in order to attract youth, they suggested that such centers host popular, constructive activities and invite celebrities to visit. Participants emphasized the need to engage youth in these activities because sometimes youth choose not to participate in such efforts. In addition to youth centers, several people stressed that youth programming, including after school programs, needs to be affordable in order to be assessable. Additionally, participants suggested supportive programming for parents that teach parenting skills and

advocacy for their children. Finally, participants endorsed structural changes to Harford Public Schools that included better training of teachers, reduced class size, and less spending on privatization of school management and charter schools.

### **Community Engagement**

Community engagement was identified as an overarching theme that was embodied in all other themes. Repeatedly, many struggled with how to balance needed structural supports for health and how to improve the community's "mentality." Participant 36 simply noted, "*You know, as much as there are different things happening to help, a lot of people just don't care.*" Here, she contextualized that even when structural supports are implemented to support healthy choices, people do not always choose to take advantage of such opportunities. In describing this complexity, Participant 15 said:

*Going back to a mentality thing where if you live with roaches and rats, and your hot water don't work, and you can't pay rent, and no food in the fridge, and all that, you think you are going to go up and clean trash? You are not going to litter? You are not going to be violent? You are not going to use drugs? You are not going to hang out on corners? You are not going to do all of these positive things and be a community person? Your mother is on drugs, you don't, you never met your father, you father's not there, all that, those are the issues that cause, the root issues that cause the behavior is what is more difficult, the idiosyncrasy of the mindset of the psyche that have to be addressed that people aren't, it's just more so getting to the upper level where they actually implementing things that will address those issues.*

Here, Participant 15 highlighted that when people are surviving poverty, it is perhaps unrealistic to expect that their mental focus would be on community connection. Yet, he also suggested the importance of accessing the "upper level" policy makers responsible for the root conditions of poverty. He also stressed that maintaining hope is a major challenge to community engagement, "*A lot of them lost hope already, why they are either not caring or [suggest] 'Yeah, my vote doesn't matter which is what most people are going to say. And truthfully, it hasn't made much of a change when you even do vote, so...' "*



Community engagement in the local policy arena was valued, though this issue was wrought with complexity. Participant 4 emphasized:

*There are people engaging. There are organizations but it can take lifetime. You could spend your whole life fighting these issues, fighting the city hall, to make changes. It's not like people are not doing anything, there are many people doing much here in the city of Hartford.*

Two participants identified themselves as advocates in the city. Participant 36 emphasized disproportionate resources that privilege some advocates over others: *"Some people in Hartford, they do fight but they just don't have the resources to fight effectively as other places. They do fight."* Participant 10 validated the importance of advocacy by noting, *"Everybody's voice matters. Yeah even if you come and you know go to the City Hall and speak your voice—one person is better than zero."* And, Participant 3 suggested that people need to face personal fears about being rejected in order to speak out and be heard: *"People are concerned, but you find a lot of people that are afraid to voice their opinion. They get right there and they clam up."* She suggested that everyone needs to be supportive of others speaking their truth.

Many participants also highlighted that Hartford struggles with cohesiveness across its

**Figure 4.17: "Unity"**



diverse communities.

Figure 4.17 is an outdoor mural that stood out to participants; Participant 36 noted, *"This community art depicts unity. It's an example of what the community should be. I personally don't think that*



*our community is at this point yet, but this represents...what we want to be working towards.”*

Some emphasized division that they perceive between different parts of the city, particularly between the “north” and “south” end. Participant 5 said: *“There’s prejudice. I see it all the time. They feel...that they are lesser. They feel that they are poor. The south end feel more. They feel uppity. The north end is lower class.”* Participant 38 also spoke to this issue:

*I think this brings up the issues, kind of like, the difference between Elizabeth Park and Kinney Park, how we are Hartford, we are one city. But then you have the people in the north end, the people in the south end, the people in the west end. There is still a separation where I feel there shouldn’t be. Because we are all Hartford. So why should I be afraid to go to the north end? That’s my city. I hardly ever go to the north end, I’m gonna be honest with you. I go when I have to go. But for me to say I’m going to go to the north end because I’m going to this place, I’m going to go to that place, I got errands to run. No. I run all my errands on my end of the neighborhood. Because it is what I am familiar with and I am usually here. Oh my god the north end, I’m going to get shot up or something like that! And that’s my own fault, because I should feel comfortable going anywhere in my city and you know, seeing people in my community and being like, “Hi good morning,” or whatever, but you won’t catch me walking on the north end on the street by myself.*

**Figure 4.18: “Community Gathering Spot”**



Many people discussed a key barrier to coming together as a city are widely held perceptions about the differences between the different communities within Hartford.

Similar to the suggestions involving other themes, most highlighted the importance of creating public spaces that encourage people to come together and interact (see Figure 4.18, a popular downtown place for community events). Participants also noted the importance of “programs” that would promote the well-

being of community residents, such as affordable and assessable athletic, art, and other extracurricular programs for children, and educational programs for adults on a myriad of topics such as advocacy, gardening, and job training. Prevalent around the city, graffiti tags were interpreted as a nuisance, but also seen as an opportunity to involve graffiti artists in creating engaging public spaces. Finally, while they did not offer concrete suggestions for addressing this, participants emphasized the need to motivate community members to make healthy and responsible choices, because ultimately it is each individual's personal responsibility to do so.

### **Summary of Findings**

Thematic analysis of focus groups and critical dialogues (i.e. Stages I, III, and IV) led to the categorization of health into three major domains—physical wellness, mental and emotional health, and spirituality. Thematic analysis also revealed eight key themes involving participants' perception of factors that affect the health of city residents: Access to healthy food, access to nature, housing and homelessness, substance abuse, litter, education and role models for young people, community investment, and community engagement. Participants' suggested recommendations to improve health in Hartford were identified for each theme.

The concerns that participants discussed primarily involved Hartford residents' basic needs and quality of life. Their call for improved access to healthy food, better job opportunities, and additional safe, affordable housing units, related back to participants' sense of survival. They suggested that improvements in infrastructure to help ameliorate these problems would also improve health. Moreover, litter and drug activity were often tied to perceptions of unclean, unsafe, and undesirable neighborhoods; their ubiquitous existence were viewed as a consequence of residents' survival mentality, and implied that Hartford was an unpleasant place to live.

Participants also identified several health-related strengths in the city—these included, but were not limited to parks that promote green space, a well-resourced, holistic community center, supportive housing services, and community gardens. However, in order for people to effectually capitalize on these strengths, participants repeatedly identified the need for better awareness among community residents about available services, commodities, and opportunities. Participants requested improved information sharing regarding several identified themes. For example, in observing established community gardens in their neighborhoods, participants were unsure if or how they could be involved. There also was considerable confusion regarding policies and programs for bulk-item, trash pick-up. And, people were uninformed about promotions for Hartford residents from local amusement and recreation facilities, such as free tickets at a movie theater. The idea of a public awareness campaign was suggested as it related to publicizing all of these valuable assets.

Participants also suggested the all Hartford stakeholders—particularly residents and policy makers—need to be more accountable. Many suggested that the people who live in the city should be less selfish and more considerate of their community; participants highlighted that in order to reduce littering, curb addiction, and enhance civic participation, individual attitude change would be necessary. At the same time, participants emphasized that city leaders need to directly prioritize the needs of Hartford residents. They agreed that it is unfair and ineffective to simply blame residents for Hartford's challenges when elected officials should be more liable for their leadership. They suggested that public resources could be better invested in responsible, community development that will maximize benefits for residents, as well as improve essential, engaging, and educational programs for Hartford's youth.

## CHAPTER 5: COLLECTIVE EFFICACY

One of the main objectives of this study was to explore whether the critical consciousness building process inherent in photovoice methodology may enhance the collective efficacy of a community. As noted in Chapter 2 (Methodology), data from the focus groups, small group dialogues, and large group dialogues (e.g., Stages I, III, and IV) were analyzed using structural coding to identify themes related to critical consciousness and collective efficacy, and magnitude coding to identify the intensity of the codes. This chapter discusses findings related to critical consciousness and collective efficacy. First, findings involving critical consciousness and the process of conscientization are shared. Then, qualitative and quantitative data on collective efficacy are presented. To summarize the findings, there is no evidence to suggest that the critical consciousness building process inherent in this photovoice study has increased participants' collective efficacy.

### Critical Consciousness

Consistent with photovoice methodology, which inherently promotes conscientization, participants demonstrated evidence of critical consciousness throughout different stages of the study. For example, a longtime Hartford resident and community activist, Participant 11, brought critical awareness to group discussions. She shared an important insight regarding space within the community, and how it relates to housing, property ownership, public space, and food access.

*The housing and homeless epidemic sort of ties into what we see with our community gardens today...It's challenging because I see where we are trying to go with doing all of these community gardens, but one of the things that it negatively impacts us is that all of this land where the houses have been removed from, if we turned all of them into community gardens, you lose the opportunity for housing to go there...And even though the land is still available for somebody [to] buy...if I live in a community and it's a garden on it I usually tend to overlook that piece of land and go to somewhere else. So*

*now you have a garden where what you could be doing is educating the people to plant gardens in their yards so that the land is available for sale.*

She went on to elaborate that land being borrowed for gardens, which seems to be well purposed to many community residents, may also be seen as valuable investments to outsiders:

*Our garden on Enfield Street is through Knox but Knox actually... don't own the land. The land is allowed for them to use until it's for sale. But if I live on Enfield Street and I see a garden everyday on Enfield Street and I finally get out of debt and I able to buy land I usually bypass that because there is something there. But people on the outside, our gentrifiers, they know that land doesn't belong to the neighborhood. They can come in and buy it and then you lose the opportunity to become homeowners in your own neighborhood. So it's a double-edge sword.*

Participant 11 has thought carefully about the complex social problems facing Hartford, which involves the intersection of different social issues, and integrated the following themes from the findings outlined in the previous chapter: access to healthy food, housing and homelessness, and community investment.

In another conversation, Participant 11 emphasized that personal, health-related choices are contextualized by opportunities people have in their local communities. To illustrate an example, she described how the food she ate at the Stage III critical dialogue was not simply a result of her own decision to make healthy choices, but ultimately a consequence of the healthy menu that was served to participants. She elaborated how this experience occurs in her community: *“Whatever comes into being allowed into the community is usually done through leaders in the communities, through dialogues and conversations...So it's very important... most things start for us...because somebody else is thinking of it, bigger picture.”* Participant 11 demonstrated critical insight into how leaders with power and community influence shape health access, both as gatekeepers of health-related information and via decision making. She added another example illustrating how the recently closed Hartford landfill contributed to the poor health of Hartford children: Despite research showing the deleterious effects of trash on the

health of local residents, policy makers still allowed this landfill to operate. Yet, she emphasized, many people in Connecticut who are not from the city simply blame Hartford residents for their poor health without acknowledging these broader environmental impacts.

Additionally, Participant 4 shared critical insight regarding diet and food choices that, he noted, were rooted in slavery and have led to health inequities. He summarized his process of conscientization as follows:

*Ever since I was a child, in the African-American community, there's always been health issues that a lot of other ethnic groups have never had. For instance, a high rate of diabetes and hypertension with salt and all these things. Now the issues have changed. I'm a Muslim, and this is one of the reasons I became interested in the Muslim community because during the '60s and '70s, they were the ones to make aware in the Black community the foods that you're eating. I've noticed that, for instance, my grandfather [and] a lot of [others] had a lot of health issues due to the foods that they eat, basically. I became very aware to avoid all those issues because I didn't want to die in the same conditions.*

He went on to explain that he believes that these dietary patterns are rooted in slavery; during slavery African Americans needed to learn ways to stretch food, particularly pork, which has resulted in unhealthy, but culturally-relevant diets.

### **Conscientization**

Support for the formation of critical consciousness within this study was also highlighted in the findings. For example, evidence of conscientization involving finances was found in Stage IV; as participants brainstormed ways to improve health, the issue of budget restrictions and prioritization of funds was discussed. Their critical reflections about funding deepened as the dialogue progressed and participants consecutively discussed each of the eight themes involving health in Hartford.

Participant 15 initiated discussion on finances as part of the conversation about litter; it was the first time in the Second Critical Dialogue that any participant talked about money as it

related to their health-related suggestions. In explaining why advertising of bulk trash pick-up is so limited, he said:

*That is where, it reaches up to the government level and the actual money that is put into the effort...it costs money so it's like each state has a certain amount of money that they have a budget for each amount of things, so you don't know where they are at in their budget. And these days a lot of things are over budget. So it's like, it goes into the budget, the budget comes up a lot of times.*

Participant 15 suggested that budget limitations may yield reasonable limits on services.

Later in the dialogue, when money was reintroduced into the conversation regarding the infrastructure for city parks, Participant 4 stated, *“Isn't the City of Hartford broke? Is there no money or something like that?”* To which, several participants chuckled. Participant 5 responded, *“That's what they [city officials] always say. They always say that.”* Participant 10 added, *“Too many people have their hands in the cookie jar.”* The city budget was brought up in subsequent conversations about suggested regulations for the quality of housing and potential programming to constructively engage Hartford youth.

In the conversation regarding services for young people, Participant 27 began to critically question decisions about the city's spending. He noted, *“...rather than making these great stadiums. I mean they [city officials] can't pay employees but they got money to do stadiums when there is a need more in the inside of Hartford with the youth.”* Participant 10 then stressed:

*I believe if we was to stop paying for like these privatized management to help run our city schools, that are charter schools, my personal opinion, I believe that a lot of that money can help strengthen them issues [e.g., services for youth]... Yes, how the money is budgeted.*

Therefore, as participants' critical consciousness developed about funding, the conversation regarding resource availability evolved from seeing it as a valid limitation to questioning the legitimacy of decisions made regarding how public spending is prioritized.

Moreover, participants understood the importance of social action in “fighting” for political goals, though they were also critical of the effectiveness of such advocacy in Hartford. Two participants compared Hartford to New York City, and emphasized that New York has been more successful at providing needed services. Participant 4 emphasized how New York recently received funding to eradicate homelessness, while Connecticut has not been able to secure such funding, despite being the “*richest state in America.*” Participant 20 questioned the complacency she perceives among Hartford residents: “*Hartford never fights—if they don’t fight we won’t have. New York fights for everything, every little thing New York will fight for. We are just, we are just an ‘OK’ person in Connecticut, we just let it go.*” Both participants described Hartford and Connecticut as interchangeable, perhaps suggesting little awareness of the distinct differences in resource allocation between Connecticut’s suburban communities and its capital city.

These individuals also assessed these challenges primarily from a third-party standpoint—seeing themselves as external to the problem and the solution. This was not uncommon. Though participants recognized the importance of social action, only two people reported having direct engagement in activism. Participant 13 described taking part in a recent Black Lives Matter action in Hartford that was in response to national concerns with law enforcement and the unwarranted deaths of people of color. She described this event and her role within her community: “*We made a statement without anybody getting arrested. We were able to walk from the top of Albany Avenue to the State Capitol without making a scene...I don’t know if they heard us, but we did it.*” Referring to her activism Participant 10 said, “*I advocate. I advocate A LOT!*”



Participants emphasized the importance of getting involved, and some had innovative ideas for social action. For example, Participant 15 suggested that not only do more people, particularly young people, need to take advantage of opportunities to engage in political activities, but also that more of these opportunities are needed. He said:

*How many venues do we have such as this one? You did a research study. This opens up a window for us to speak our voices, but how many of those do we have? And, how many people would actually attend those? We have the city councils and those are more for, who's attending a city council meeting, it's more so the older generations. How many teenagers, how many kids who really need it are going to go to these types of things, to change, to better change their lives?*

Moreover, in order to draw attention to the need for improved trash removal for bulk items like furniture, Participant 48 suggested organizing residents to collectively drop off used mattresses at Hartford City Hall, thereby demonstrating her knowledge about collective action.

### **Collective Efficacy**

#### **Qualitative Findings**

Participants' perceptions of collective efficacy in their neighborhoods varied in both Stage I and Stage IV. Qualitative findings do not indicate any perceived changes regarding collective efficacy during this study. However, participants that lived in different neighborhoods reported different perceptions of collective efficacy. Perceptions of higher collective efficacy were reported most frequently by participants who described greater satisfaction with their neighborhood. Participants' descriptions of their neighborhoods reinforced the saliency of collective efficacy to their experiences.

**Stronger collective efficacy.** In Stage I, Participant 14 described a strong sense of cohesion among his neighbors, and suggested that this level of shared accountability may at times be unsafe.

*In my neighborhood, everybody looks out for one another. If a house alarm goes off, you have three people in front of their house. This is the first time I've ever seen something*

*like this. One of the mansions that's down the street from my house had a house alarm that went off. There are maybe six neighbors that actually came out of their house and surrounded this house to make sure nobody was in the house. I'm like, really? This man could be heavily armed in that house robbing it and y'all gotta come out of your house and stand around this man's house to see if anybody's in there? Are you serious?*

Participant 14 lived in zip code 06105 in a multi-unit home owned by his life partner and was grateful for the opportunity to live there. The neighborhood that he described is in Hartford's West End and is known for its beautiful, historic homes. He described where he lived as a "boughetto" because it integrates elements of an upper middle class neighborhood with what is commonly conceived of as an urban ghetto.

In both Stage I and Stage IV, Participants 21 and 38 also described a strong sense of collective efficacy in their neighborhoods. Both are homeowners who live in zip code 06114. The descriptions that they provided were consistent between the stages and also very similar to each other. Participant 21 noted that despite not personally knowing her neighbors well, they have an open agreement to look out for one another, particularly when "something happens":

*I have been living in my neighborhood for 26 years and I know the person who lives on both of my sides, to my right, to my left and in front of me but I don't know anyone else in my neighborhood. But at the same time, although we don't know each other we watch for each other...we say hello, good morning [but] that's it, that's all we share, we don't know anything else. But we had, we have a neighborhood watch in my neighborhood and when things have happened, people come out and that's when we [check in]: "Okay? You Okay? You fine? Okay," and then we go back in until something else occurs. So I do think that we do take care of each other and in my neighborhood my husband he walks the dog and he walks with a bag and he picks up the garbage in everyone else's, you know, if there is some garbage in the neighborhood, he picks it up.*

Participant 38 shared a similar perspective, and highlighted an example of an incident that successfully united her neighbors.

*It's kind of the same as with 21. I'm not in their business or know what they cook for dinner that night but towards the end of the fall, there was a car parked in the street and there was a drunk driver that shot up our street, hit the car and kept on going. Everybody was out of their houses, everybody had their cellphones trying to get a picture of the*

*license plate. You know the guy got stopped and arrested because he was driving drunk but that was all of us coming together.*

She emphasized that though there is a common sense of trust and reliability among her neighbors, her relationship with them is not very close or overly personal.

*We are not in each other's faces or anything. I see the guy from up the street coming down to take the bus. Every morning I see him, "Good morning. How are you?" and that's the extent of my relationship with that person. But we know each other, we know each other's faces. The house in front of me and the two houses on the side of me I know who lives there...not that I'm in their business all the time but I have a closer relationship [with them] because they are closer to me. Like I know the lady in front of me, she has a son that goes to school with my niece and I know Scott and Scott comes and he will come and hang out in the backyard with my niece and my nephews and stuff like that, it's not something like we are overbearing like we are in people's faces all the time. But we know each other and we look out for each other. Like if I see something funny, in somebody's yard, I'm going to be like "Hey you know, I noticed this the other day you might want to check it out." You know just stuff like that.*

As a resident of zip code 06106, Participant 27 described his relationship with his neighbors similarly, highlighting a sense of trust with his immediate neighbors.

*I live also in the south end on New Britain Avenue. It's actually a one-family house, me and my mother. Like you said, also I just know my two neighbors. I have an older lady that lives by herself with her daughter. We always say, "Hi." She's looking after my mother's house, our house, and we're always looking after her house. Then we [have] a building, a four-family building on the right-hand side. They're cool, too. My son goes over there. They hang out. So we do look after each other, which is a good thing. People across the street—we've known her for a couple years, and they don't say nothing at all. The woman and her mother—she's an older lady—but I've gone over, shoveled the snow because I know they're not able to do a lot of the stuff.*

Unlike other participants, Participant 27 also described a sense of collective trust even with those selling and purchasing drugs in the neighborhood:

*A lot of drug activity is happening there. Everybody still respects each other. You know, they see us coming. I respect them. They respect me, and sometimes I get treated more better than the people who don't do drugs when they come in. When you see them, they want to help you out. So they're just more and more open...In my area it's just stop and go. It's not like they're hanging around, and everybody else there. No, I guess they're more older, so they don't want the attention. So they go give their money, and that's it—go.*

Even though people are participating in illegal behavior, Participant 27 trusted that they are not there to create trouble and even feels that they are more invested in being helpful than other neighbors.

**Lower collective efficacy.** Participants 28 and 42, residents of zip code 06114, both reported lower levels of collective efficacy in their neighborhoods. Participant 28 highlighted that while she does not witness violence, drug activity in her neighborhood is quite blatant, which, she noted, is particularly harmful for children to see. Participant 42 contrasted her perceptions of where she lives with the next street, and thereby identified stark distinctions:

*One street over, there are no apartment buildings, and it is so quiet. People are just very respectful of each other, and each other's space. When you have a bunch of apartment buildings, and you start letting people in, and Section 8, you can see the difference. I pay a good amount of money in rent, so I expect certain things. You don't get that.*

She stressed that once “you start letting people in” you have less community respect, thereby suggesting an insider/outsider perspective that relates to her sense of community cohesion.

Participant 42 also connected her perceptions of lower collective efficacy with people receiving support from the federal Section 8 housing assistance program.

Trust emerged as an important component of social cohesion. Participants often reported feeling trustful of those that lived directly adjacent to them, but did not trust the broader community in their neighborhoods. Though Participant 3, a resident of 06112, portrayed her neighborhood as dangerous, she described a valued sense of trust with those that live in her apartment building:

*In my neighborhood, I'm right in the pit of it all...So, I'm right there, right there in the mix...There is always something going on, and it's sad...Even when I was taking the pictures, I was kind of sunk down [in the car]. I better not be caught taking pictures.*

*[But] People in my particular building is very good. We stick together. You know we watch out for one another. You know it's more like nobody is in each other business but you know if, there is something you know, something suspicious going on we are going to address one another.*

Participant 10, a resident of zip code 06120, highlighted that she too feels a sense of collective trust with only some neighbors, but she emphasized that she has hope this could change.

*Don't get me wrong. It's not everyone. You have the neighbors you can confide and trust. But where I'm at, what I'm saying, in our community the pride is really messed up. Do you know what I'm saying? I believe that can be fixed. We can move many mountains.*

Participant 10, stressed that she would like for her neighborhood to be more “tight-knit.”

*I don't know if it's a trust issue with that, because I get along, I try to get along with all my neighbors. You read the Bible it says, “you get along with thy neighbor,” but that's not the case at all times. I'm a resident of the north end of Hartford and I know my neighbor that is on my right and left of me and also that is in front of me—he is a longtime resident [and] if I need anything, you know I even go check on him to see how he is doing. That's the kind of bond I like for a tight knit community but right here where I'm at, you don't.*

*I peek out the window I see stuff, and I say let me roll this blind back down and set my TV because if I see some things it's like you know, how do you address it? Because you be like, you [get] labeled as a snitch if you see, and it don't even have to be like murderous stuff but anything that's being told in the community—you telling them about the neighbor, oh you [are] snitching.*

*If you want to help the community even if you want to help assist with that neighbor. Some have their nose to in the air, like one I know she needs help and she lives on the right side of me and I really try to help you know but you just have to love sometimes from a distance. I did, I tried... Where I'm at, I've been there for three years. The old Number 10 [used in place of first name] probably would have been over there...really loud mouthing. But you're not going to get, you know, up by doing that. It's not going to you know prove nothing. You know just stay doing what you can do.*

Participant 10 emphasized that her neighborhood values privacy over friendship, thus implying that shared trust is very poor. Therefore, even if one has the best intentions, getting too personal with neighbors is interpreted as a betrayal of trust.

**Efforts to increase collective efficacy.** Participant 11, a resident of zip code 06112, contrasted different perceptions of collective efficacy based on her experiences living in different neighborhoods within the northern part of Hartford. During group discussions, she was the only participant to identify by name the distinct neighborhoods in which she has lived. She also

highlighted how, as a community leader, she helped contribute to the social cohesion and social control on her current street. She said:

*I actually came from the north end of Hartford but in a zone called Clay-Arsenal. I was in Clay-Arsenal for about 10 years. Then I moved from Clay-Arsenal to where I am now, and I've been in the North-East community for two years. This is my second year.*

*I was on Pliny Street, prior to here. Pliny Street was primarily houses, three-family houses. There's a few speckles of apartment buildings on the street...It was a couple of years before I actually moved off of the street, when I started doing things within the community. There, people are very detached from each other. There were people breaking into my house every other week. No matter what I did on the street—treat the whole street to all types of stuff, doing community stuff—and they still rob me. Actually after about three years of doing block parties, doing gardening parties. Every holiday that came up...I tried to do something for the kids on the street, and they would come in the house and rob, steal from me. My kids would be like, "Why are you still doing stuff?" But I have a strong belief—and I still try very hard to model that in everything I do—you have to lead by example. People are used to what they've been seeing forever.*

*If there's nobody that's going to say, "Okay, you know what, I'll sacrifice the toilet paper." If you're going to come in and steal the toilet paper, my bigger agenda is more important. My main goal is more important than me worrying about you stealing the X-box. Because that \$150 can't compare with the seed that I'm about to plant. So I took those challenges.*

*I actually tried to move out of Hartford. I went everywhere trying to find a place to live and nothing would open for me...I seen this nice looking house, smack dab in the middle of Enfield Street. I said, "You know what, God, you got jokes. I thought we were moving up. I did not know I was moving over."*

*So I left Pliny Street, and I'm on Enfield Street now. But it is such a rewarding experience over on Enfield Street. When I first moved there—and these apartments, it's very diverse. There's single family houses. There's three-family houses. There's six-family apartment buildings, a lot of blighted property in some of the areas. I'm at the top of the street where most of the houses are pretty all right, but you can go further down and it's a lot of blight, and abandoned spaces. There's a lot of drug activity. But it's not overt.*

*I do a lot of community work, so wherever I live I like to try to be that example in the neighborhood. So if I live on a street, that's where the block parties are going to go...I try to beautify the street...kids aren't used to seeing something look nice...I was actually kind of shocked at some of the change that was happening around because of the work that we'll do on that particular street.*

*Somebody was walking by my house with his friends one day, one of the gentlemen that always see me gardening, cleaning up in my neighbor's yard and his friend was cursing while he walked past my house...He was like, "Oh no, you can't talk like that when you walk past this house." I'm like, "Wow," because some of these people don't care about nobody. To hear him say that meant that he's noticed a change, and that gives me the drive to even do more.*

In her description of the work she has facilitated in different neighborhoods within Hartford, Participant 11 highlighted her leadership capacity. Though persistent, she was not as effective at improving the collective efficacy in her previous neighborhood and yet, she was effective at doing so on Enfield Street. Through her sacrifice and example as a role model, Participant 11 highlighted her success in transforming behavioral norms on the street, at least in terms of what she witnesses.

Similarly, Participant 48 reported actively trying to regulate her neighbor's behavior regarding their pets. She identified animal waste as her top health-related concern in her neighborhood. In order to encourage her neighbors to pick up after their pets, she respectfully confronts them:

*As I see these people with their dogs, and I say to them... "It's a legal law to have poop scooped in the state of Connecticut. Are you aware of that?" I said, "Where's your bag at?" I see these same neighbors all the time. I said this to seven different people. Two of them really got tired of me saying it to them and now they pick up their dog's stuff. I used to say to them also, "You know, summertime is coming. There are kids that play in this grass. Why don't you start picking up your dog mess now, so kids don't have to fall in that?" Cuz there are windows on the level where dogs shit at. I said, "Do you know if the wind blows this way and that shit smell's going in that person's house?" You know, and I say things like that to them. And only two out of the seven. But I still say things... "Where's that bag?" But I say in a happy way or smiley way. You know, I don't have an attitude.*

In this quote, Participant 48 highlighted attempts to influence the behavior of her pet-owning neighbors by politely challenging them. Though she also noted that while she is consistent, only some people have changed their behavior, suggesting that she has not been effective at regulating this behavior.

**Broader insights involving collective efficacy.** Perceptions about collective efficacy expanded from participants' immediate neighborhoods to include the entire city. Participant 15 noted that in Hartford, while people may feel a sense of reliability and trust with their immediate neighbors, this is not the case across the entire city.

*I was astonished when I went to Walmart and I saw the wall of missing children. If anybody is unaware of that, go to Walmart, the Hartford Walmart, and look at it. They got like a mural of missing children. They wasn't little kids, they was teenagers and missing...If [it] was a tight knit community or whatever, then how could you not see this person at all? ...And also just all the unsolved murders that go on. It's like, that's another [issue]. It's like if we are on the same page, how is this possible? That's why I said widespread not as much, but in, in you niche, in your area you might be on the same page.*

Participant 33 echoed concerns about violent crime, and criticized the lack of shared responsibility among Hartford residents: *"People getting killed in front of the store...drive by, innocent people. Too many cold cases up here. Nobody ain't known nothing, nobody ain't seen anything, but it was crowded when it happened."* There was a sense among many participants that as Participant 50 described, people primarily *"mind their own business."* He added, *"It's sad that where we live, it's like that. But it's true."*

Participants connected perceptions of poor collective efficacy with challenges related to survival. Participant 3 related the lack of unity in the community to increased violence, particularly in light of the other struggles residents face. She noted:

*It's a shame we have to live in a town called Homicide Hartford. You know, it's just scar...Regardless of whether we claim it or not, it's out here. And, and it's really frightening...If there was more unity among us, it would be a much better place. But how do you reach out to the young ones...that are so corrupt at nine? Half of them, they coming from homes that you know are broken, and they have this chip on their shoulder. You know, and how do we reach out to them? ...A lot of the parents or so called parents of today, they're there in the home but they are not there at the same time. So the children, you understand, just do what they want to do. And this is becoming the outcome of it. You know, the anger that lurks within them is pouring out.*



In this way, she suggested that community violence represents a lack of unity, which is the consequence of struggling families and the subsequent anger children experience at home.

Similarly, in sharing a personal story, Participant 11 implied that a lack of humanistic connection among residents of Hartford is the result of mental health challenges that the community is facing:

*I was walking down the street. I said, "How you doing?" to a gentleman walking by me. He stopped and turned around. He said, "Where you from?" I said, "Born and raised Hartford." He said, "You got to be lying because I've been on vacation up here with my family for two months, and you the only person that ever said, 'Hi' to me. I would have sworn you were about to tell me you was from Georgia, or something." Nobody in Hartford said, "Hi," to a stranger for two months? I had to be from another planet just to say, "Hi?" But that's that anger and that animosity in the people in the community and it's blowing off on people. I believe it has a lot to do with mental health. Because if you are healthy inside, and in your mind, nothing would stop you from wanting to be polite to your neighbors. Why can't we do that in Hartford? Why I got to be from Georgia? I only been there one time.*

Moreover, in describing the barriers to appropriate trash disposal, Participant 15 highlighted that people's self-centeredness can be a challenge when a person is facing eviction. He said:

*The larger part of that is the people don't care, or they are unaware or they don't care. If you are getting evicted they are not worried about putting [trash] out on a certain time. It's the mentality also, so curbing that mentality is going to be more difficult on a widespread, community basis.*

Thus, the issue of personal responsibility that was found to hinder community engagement was also connected to a decrease in shared expectations regarding the proper disposal of trash, particularly when someone is facing a personal crisis, such as eviction. Participant 15 is perhaps suggesting that in such cases, personal priorities trump shared expectations, and yet, this attitude reinforces individuality and weakens the social cohesion within the community.

Some participants highlighted that even in the face of shared community concerns, they need to remain focused on their own well-being, even if this means sometimes turning a blind eye to others. Participant 13 said:

*This might sound like selfish, but because I have run the streets getting high, and because I'm trying to live the recovery way, every day is a challenge for me to stay sober in an environment I used to get high in. So it's like sometimes I put the mask on. Like yeah, go to my recovery meeting. Stay around positive people. It's sad. I do see it, but I don't want to, I can't entertain it. I can't go across the street in that little park because across the street, that's where I used to hang out. So if I go over there, it's run through it. It's basically protecting myself at all costs. Sometimes I feel like survival of the fittest—only the strong survive. Some days it's like that. It's selfish, but I'm sorry. I feel selfish at times.*

This sense of the need to survive detracts from participants' collective efficacy: many participants reported needing to separate themselves from their neighbors in order to stay well. Participants 13 and 50 both spoke to this challenge.

### **Quantitative Findings**

When measured by responses on the Collective Efficacy Scale, there was not a significant change in the level of collective efficacy reported by participants from pre to post-test. Of the 24 participants active in the study, 11 took both the pre and post assessment; due to attrition, this was an unexpectedly small sample size. Pre and post-test scores on the Collective Efficacy Scale ranged from one to five, with one being the lowest and five being the highest. The mean score on the Collective Efficacy Scale pre-test ( $M = 3.17$ ;  $SD = .566$ ) was higher than the mean post-test score ( $M = 2.93$ ;  $SD = .616$ ). Of the 11 participants, relative to their pre-test scores, four had increased post-test scores, six had decreased post-test scores, and one scored the same.

### **Summary of Findings**

Neither qualitative nor quantitative findings definitively demonstrate that during this study, participants' collective efficacy increased. Results from the Collective Efficacy Scale suggest that on average, collective efficacy scores actually decreased. Qualitative findings

demonstrate evidence of participants' critical consciousness and conscientization that evolved throughout group discussions. All 11 participants that took part in Stage IV reported that they feel more tuned in to what is happening in their communities after having participated in this project. Rather than directly effecting collective efficacy, perhaps the critical consciousness building process that was integral to this study made participants more aware of perceived deficits regarding their community's social cohesion and social control.

At the same time, it is possible that participants' increased critical consciousness may eventually result in behavioral change that could indirectly strengthen collective efficacy. As a consequence of deeper critical awareness that evolved during this study, in time participants may be more likely to reinforce behavioral expectation when interacting with their neighbors that support health and community well-being. For example, as a result of stronger critical consciousness, they may be more likely to challenge neighbors when they witness them throwing litter on the ground, or they may be more likely to get involved in a neighborhood community garden. In this way, perhaps the process of conscientization inherent in this methodology may have longer-term, positive effects on collective efficacy. Future prospective studies are needed to confirm this hypothesis.

## **CHAPTER 6: DISCUSSION**

This chapter conceptualizes the findings of this study in the broader literature and discusses their implications. First methodological limitations are reviewed and the process of reflexivity is examined. Next, suggestions for future research and implications for practice are discussed. Finally, a contextualization of the findings within the local context of Hartford, Connecticut is provided as well as their relevance for social work education. This dissertation concludes with a brief summary of the study findings.

### **Limitations**

Sampling bias was a limitation in this study. No one living in zip code 06103 at the time of enrollment took part in this study, and 11 participants (45.8% of the sample) lived in zip code 06106. In hindsight, instead of aiming to have an equal number of participants from each neighborhood, it would have been more appropriate to have the size of each quota be proportional to the residential population within each zip code. Additionally, African Americans/Blacks were disproportionately over-represented in the sample and Latinos and “others” (e.g., identifying as White, Asian, or multiracial) were under-represented compared to what was originally planned. The fact that the study was conducted solely in English likely contributed to fewer Latinos participating. Also, the sample did meet the overall quota regarding gender, though women were slightly better represented than men.

Interestingly, however, this sample looks different from most other qualitative studies that are conducted at the Hispanic Health Council (HHC); in general, focus group samples of Hartford residents facilitated by the HHC tend to be more Latino and predominantly women (D’Angelo, Ruiz, & Damio, 2016; Hispanic Health Council, 2013). This is not surprising since the agency specializes in working with Hispanics and its service programs target mostly women.

Nonetheless, this difference emphasizes the effectiveness of recruitment in this study, particularly with Black/African American participants, men, and people living in the northern part of Hartford. In the decade that I have worked at HHC, this was the first time that a study explicitly sought to include participants who lived in neighborhoods across Hartford. Several participants reported that this study was their first time working with the HHC. It seems, therefore, that despite sampling bias, the study was effective at bringing together diverse residents.

Attrition was also a limitation in this study. Of the 28 participants who enrolled in the study, only 11 (39.2%) remained active through Stage IV. Attrition made it difficult to qualitatively and quantitatively assess changes in participants' perceptions of collective efficacy. A power analysis revealed that with a sample size of 11 there was not enough power to yield statistical significance on the pre/post Collective Efficacy Scale; a minimum sample of 21 participants would have been needed for a medium effect size with regard to collective efficacy, with 80% power at the  $p < .05$  level.

As noted in Chapter 3 (Sample Description), the high attrition was primarily due to participants becoming lost-to-follow-up and unreachable during the duration of the study. Participants who remained engaged were more likely to also have been employed, thereby suggesting that those who dropped out may have been more marginalized. The attrition bias also implies that many participants in the sample were struggling with vulnerable life situations (e.g., homelessness, substance abuse, mental illness). Considering that such people tend to often be excluded from conventional research, their involvement in even just one stage of this project captured some of their voice. Therefore, although it was limited, participation of this population was ultimately a strength of this Community-Based Participatory Research (CBPR) project.

In order to reduce attrition, it would have been best to minimize the time that elapsed between each stage; this, however, was a particular challenge given that specific research protocols for subsequent stages were based on initial findings from the preceding stage(s). Stages II through IV each required full-board IRB review and each approval took between three and eight weeks after amendments and materials were submitted. This was a time consuming process. Perhaps, if the study was better resourced, added infrastructure such as paid staff could have helped to expedite the time between stages; staff could have assisted with drafting IRB amendments, the creation and revision of tools, and preliminary analyses.

Additionally, using the zip code as a proxy for neighborhood in this qualitative study was not valid. Four participants (16.7%) reported residing in transitional housing and as a result, moved during this study; this level of homelessness and transience was not expected and may have further weakened neighborhood identification. Perhaps it would have been more accurate to include only residents living in permanent housing at the time of enrollment, though that would not have controlled for those that were displaced during the study. Two participants also reported living in one zip code but when they described their neighborhoods, they spoke about a different area on the other side of town; this led to questions about where participants actually identified as “home.” Additionally, participants who lived in the same zip code reported distinctly different answers from one another when self-identifying their neighborhoods. While no other clear, valid measure of neighborhood construct appears to exist in Hartford, the findings of this study suggest that the zip code was not perceived to be meaningful and therefore may not have been a reliable indicator of neighborhood for qualitative research in this sample.

### Reflexivity

From the conception of this study and throughout its evolution, I have been mindful of my positionality as a well-educated, White, middle class woman, who does not live in Hartford. All of my participants were city residents, the majority of who identified as non-White. Most participants also had limited formal education and were struggling through poverty. Considering this, I come from a relative place of power and was likely perceived as an outsider, as well as “the expert,” by most participants. Conversely, I am also a woman, and younger than most participants, which is emphasized by my petite physical stature and youthful appearance. These characteristics may have, at times, undermined my perceived credibility; for example, more than one participant has affectionately called me “baby.” Noting these distinctions involving my intersectional identities, I come from a place of formal privilege in my role as researcher, which is reinforced by my class and race privilege; and yet at the same time, my authority was sometimes undermined due to my gender and age.

In one example where my integrity was questioned, a Black, middle-aged, boisterous, female participant adamantly insisted that I give her money when she returned her photographs to me; this was not part of my previous negotiations with her or any participant. When I declined to do so and instead offered to review the study protocols with her as outlined on her signed informed consent form, she retreated in her demand stating, *“No, it’s OK, I am still going to participate. I just have to run my mouth...[laughter] But shoot! I really need \$40 today.”* While admittedly, this was a tense moment for me, in retrospect, it was an example of this participant testing my boundaries regarding our previous agreements. Perhaps it was this moment, and others like it, that built the collective trust over the course of this process, which facilitated our ability—participants and researchers alike—to co-create meaningful discussion. It

was through these active negotiations that we were able to confront and navigate perceived differences in positionality and power. As it turns out, this same participant remained engaged throughout the project, and despite her self-disclosed anxiety about public speaking, in essence became a leader among her peers in both small and large group discussions.

Additionally, I needed to carefully negotiate my leadership as a facilitator with a Black, middle-aged, male participant who consistently attempted to challenge me during group discussions. He actively took part in each stage of the study, and at one point in each group discussion, he attempted to deflect questions that I poised to the group back to me. I did not perceive this to be inappropriate as it was not incessant, and I perceived the questions to be genuine and not meant to be distracting, funny, or obnoxious. He was skeptical, however, of the aims of the study, and possibly of me as the facilitator. Generally, his questions involved asking me what I thought about the challenges that Hartford faced and if I had hope that they could be ameliorated. He was clearly jaded and grappling with the complexity of the topics discussed.

This posed an ethical challenge. Considering that this was a research study and my role was as a facilitator, not participant, my answers were irrelevant; while I clearly have opinions on this topic, I was cautious not to bias the group with my ideas or feelings. At the same time, I realized that it was important for me to demonstrate reciprocity with participants, and to confront the power differential inherent in the dynamic between researcher and participant.

When I was first challenged, I chose to briefly respond by echoing the perspectives of what other participants had shared, thereby validating their views. When specifically asked if I was hopeful about the possibility of change in the city, I verbally recognized the grave challenges that I heard others highlight, but I also emphasized that this project and the participation of everyone involved reinforced that people do care and are working to improve



their city. Later, when I was confronted in another discussion, I deflected the question with the excuse that sharing my response would take away valuable time from the group process. The participant accepted this response, and perhaps he and others interpreted it as me again adhering to negotiated guidelines involving study protocols and aims.

Although I was put on the spot with many of these questions, I consciously tried to balance my responses with an appropriate level of personal disclosure. In reflecting on my reactions, I suspect that my social work training influenced how well I navigated these situations. I believe that my authenticity and transparency as a person helped to build trust and rapport with participants, without heavily influencing the findings. Interestingly, this same participant who challenged me noted at the end of Stage IV that in reflecting on this ongoing research process, he sees how things have somewhat improved in Hartford, albeit slowly and slightly. I interpreted his disclosure as an indication of his strengthened hope, which I thought might be a consequence of our collective group process. Perhaps his ongoing participation also implied that with my limited revelations, I passed his tests.

It is also important to note that almost all of the participants in this study brought with them personal histories involving trauma and survivorship, and all demonstrated strength and resiliency. From the personal stories that they shared, I learned that one participant grew up in the custody of the child welfare system. Another had been working in the World Trade Center on September 11, 2001, subsequently joined the U.S. military, and spent years in active combat in the Middle East. Two participants were widowed, several were formerly incarcerated, many were in recovery from substance abuse and addiction, and some were still actively struggling with addiction. Several participants were homeless or lived in temporary housing, many struggled with physical and/or mental illness, and most were disabled or in-between jobs. The

participants' life stories contextualized their worldview and my life story also contextualized mine; I, too, share a personal history of trauma and from my perspective, this is something that connected me to them. In being reflexive, I believe that it was important to recognize my own parallel life struggles, so that I may have consciously supported the empowerment of the participants in this study and to witness their experiences from a genuine place of respect, rather than reactivity or countertransference. At the same time, I was conscious of the fact that I am not a person of color, nor have I lived in poverty; therefore racism and classism have likely exacerbated the trauma experienced by participants in ways that I cannot fully empathize with. By consciously being mindful of my own positionality, including both my intersectional identities and my trauma history, I attempted to be more objective in my observations of participants and more conscious in how these considerations may have affected the research.

There are several examples of how I negotiated these challenges. For example, at two points in this study, participants who were enthusiastically engaged suddenly became lost-to-follow-up: although they were once active in participating in the study, they unexpectedly became unreachable. Also, despite having previously contacted me periodically to check-in regarding the study, they no longer called or visited the agency. In one example, the participant's mother told me that he was missing for several weeks when I called trying to inform him about the study. In both situations, in addition to feeling disappointed that they would miss out on the next phase of the project, I became concerned for their well-being and worried for their safety. These concerns were accentuated by the fact that both participants had a history of behavioral health challenges and were in particularly vulnerable living situations. Despite my apprehension that they may be in trouble and desire to offer assistance to them, I consciously remained focused on my role in this study as researcher and the boundaries we had co-

established regarding our formal roles in this project. More specifically, I did not try to locate them in the neighborhoods in which they lived or the places in which they worked.

Moreover, I consciously was aware of these same boundaries in my interactions with participants. I was also cognizant of the fact that this was a CBPR project that involved a *shared goal* of social change, and therefore mindful of my role as a compassionate researcher, and not as a clinician working to direct clients toward behavioral modification. This sometimes resulted in minor ethical dilemmas. For example, I was emotionally triggered when one of the participants was meeting with me at HHC for the initial consent process and demographic survey. During our meeting, this participant's toddler daughter had a tantrum. From my perspective, the participant reacted harshly by yelling at and spanking the child. In response, the child stopped crying and seemed to be otherwise okay. In witnessing this, I became alarmed for the emotional well-being of the toddler but reminded myself of my primary role as researcher. This type of discipline may be controversial and inconsistent with my approach. However, based on the safety clause outlined in the informed consent form that delineates the criteria in which I may purposely breach confidentiality in order to protect the safety of the client or someone else, in this case I did not sense that the child was at immediate risk of physical injury and it was the parent's right to choose how to parent. In being reflexive about my reactions and role, I decided that it was not my place to offer parenting guidance to this participant, nor to report this case to the state's child welfare agency. This interaction reminded me of the messiness of CBPR and of the importance to remain cognizant of my positionality as a CBPR researcher.

### **Implications for Future Research**

This study parallels priority areas identified in the recently released Grand Challenges for Social Work, which seek to improve individual and family well-being, strengthen the social

fabric, and help create a more just society (American Academy of Social Work and Social Welfare, 2016). Particularly connected to this study are the following challenges: Closing the health gap; ensuring healthy development of all youth; eradicating social isolation; ending homelessness; reducing extreme economic inequality; achieving equal opportunity and justice; and advancing long and productive lives. Walters and colleagues (2016) highlighted that social workers may make unique contributions to eliminate health inequities by “improving conditions of daily life, advancing community empowerment for sustainable health, cultivating innovation in primary care, promoting full access to health care, generating innovations in research on social determinants of health inequities, fostering workforce development, and stimulating multisectoral advocacy” (p. 3). They spurred a call to action for social workers to contribute to research on the social determinants of health, the development of unique approaches needed to address social, economic, and health inequities, and interprofessional collaboration. As outlined in the implications discussed below, this study is well aligned with this recommended area of research, and the findings make a contribution to the knowledge base on social determinants of health and professional practice.

### **Collective efficacy**

Findings from this study on collective efficacy provide important insights. First, as is consistent with Sampson et al.’s (1997) operationalization of collective efficacy, the results of this study reinforce that in Hartford, Connecticut, social cohesion does not equate to strong social ties between neighbors. Repeatedly, when describing tight-knit neighborhoods illustrative of stronger collective efficacy, participants qualified that although they trusted their neighbors, believed that they were reliant on one another, and looked out for each other, they were not close friends. Participants 21 and 38 emphasized that although they could count on their neighbors to

check in with them and be attuned to potential concerns, they did not have personal conversations with their neighbors and they stressed that their neighbors were not overly involved in their business. In fact, no one reported knowing the names of anyone in their neighborhood besides immediate neighbors. Unlike social capital theory, which assumes that relationships between neighbors are necessarily strong and intimate in order to facilitate networking, qualitative findings in this study highlight that even with desired distance between one another, neighbors shared expectations for informal control. In this study, examples of informal social control involved participants monitoring the behavior of people in their neighborhood and intervening when concerns arose; these are consistent with Sampson et al. (1997) and Sampson (2012).

Methodological constraints likely impacted the lack of evidence to determine whether participants experienced a change in collective efficacy in this study. The limitation regarding the zip code has already been discussed; since the zip code was not found to be a reliable indicator of neighborhood, the validity of both the qualitative and quantitative measures of collective efficacy is undermined.

Sampson's landmark, quantitative research on collective efficacy used neighborhood clusters as the indicator for neighborhood, not zip codes or participant self-identification. "Neighborhood clusters" were operationalized as equally sized units of measurement that were based on two to three census tracts and contained approximately 8,000 people (Sampson, 2012, p. 79). In order to be comparable, it makes sense for the unit of analysis to be consistent and equitable, yet to date, there has not been an operationalized definition of neighborhood that is meaningful to residents. In Sampson's work, neighborhood identification was not assessed, and participants' associations with their neighborhood may not have been consistent with their

prescribed neighborhood cluster. Additional research is needed to explore measures of neighborhood identification that are meaningful to participants; a more significant definition of neighborhood identity would be especially valuable for qualitative and intervention research.

Additionally, previous research on interventions to improve collective efficacy targeted primarily the neighborhood level, not the entire city (Ohmer, Warner, & Beck, 2010; Teig et al., 2009). Perhaps the very small sample size in each zip code meant that there was not enough participant density to influence changes in participants' overall perceptions of their neighborhood's social cohesion and social control. While not statistically significant and with limitations in power due to the sample size, over half of participants in this sample reported a decrease in their collective efficacy score and in the Stage IV group discussion, no one reported a change in his/her perception of the collective efficacy of his/her neighborhood. While preliminary, this finding may imply that as a result of the critical consciousness building process inherent in this methodology, participants more critically assessed collective efficacy in their neighborhoods. More research is needed to fully assess these relationships. Conceivably however, an increase in critical consciousness could have resulted in a perceived decrease in collective efficacy, particularly without the photovoice intervention being robust enough to impact collective efficacy at the neighborhood level. If the critical consciousness process led to stronger collective efficacy, a perceived change in collective efficacy may have been more likely if more people in the neighborhood took part in the photovoice process.

If this study were replicated, in order to increase the robustness of the methodology, it would be best to ensure that the sample size at the neighborhood level is more substantial. Additionally, perhaps four group sessions, spread out over more than a year, did not have the maximum effect on participants' critical consciousness and collective efficacy. In order to

improve feasibility, it may be best to implement the photovoice process with an already established, neighborhood group, where members meet more frequently and have buy-in, such as an active block watch group, Neighborhood Revitalization Zone or the Parent/Teacher Associations of a neighborhood school. If participants were meeting periodically in between study stages for regular group meetings, it would potentially enhance group continuity and decrease attrition. Or, if ample resources were available, perhaps a larger scale study that incorporates simultaneous photovoice processes in different neighborhoods would be appropriate; this would facilitate a larger sample size for statistical analyses and would still allow for the engagement of diverse stakeholders, particularly if the intervention integrated all groups in some of the critical discussions.

Uchida, Swatt, Solomon, and Varano (2013) emphasized the value of interventions that attempt to impact the nature of relationships within the neighborhood. Their recent study of collective efficacy emphasized that these community-level processes are complicated and multifaceted, and that even within neighborhoods, residents' sense of mutual trust as well their willingness to intervene may differ. This finding was consistent with this study in that participants' descriptions of neighboring streets sometimes differed in their sense of shared trust and social control, as compared to the street in which they lived. Uchida et al. suggested that interventions aimed at increasing collective efficacy do not need to target the entire neighborhood, but instead should focus on micro-level "hotspots" that are struggling with social control. Therefore, it may be impactful to replicate this study within a much smaller, but targeted geographical area, such as a neighborhood block or residential complex that has been identified as a hotspot in terms of social disorganization.

## **Healthy People 2020**

The implications of this study regarding collective efficacy and the eight health-related themes are congruent with Healthy People 2020's Social Determinants of Health initiative. Healthy People 2020 is sponsored by the Office of Disease Prevention and Promotion of the United States Department of Health and Human Services. Its aim is to increase longevity, eliminate health inequities, create social and physical environments that promote good health for everyone, and support quality of life across the life span (Healthy People, 2016a).

Healthy People 2020 emphasizes the importance of place in facilitating social and physical environments that promote health; the five key themes of the social determinants of health include economic stability, neighborhood and built environment, health and health care, education, and social and community context (Healthy People, 2016b). Social cohesion, a major component of collective efficacy, along with civic participation, and community perceptions of discrimination and equity are specified domains of the social and community context, yet there are no identified, measurable objectives to assess them. As the federal government begins to strategize about its next phase of this initiative, Healthy People 2030, it is important for it to implement measures involving the social and community context, given that social cohesion is highly correlated with health. Sampson et al.'s (1997) Collective Efficacy Scale or another, simpler, standardized measure of social cohesion would add value to the evaluation of place-based, health-related interventions, particularly because it would allow interventions to be compared with regards to their effects on neighborhood solidarity.

## **Self-Reported Health**

The inclusion of the single-item, self-reported measure of participants' overall health yielded unexpected results, which were inconsistent with the qualitative findings. This item is



the most widely-used indicator of self-rated health in large-scale surveys in the United States (Hays, Spritzer, Thomson & Cella, 2015). It is also the first item from the 12-question, Health Status Questionnaire-12 (HSQ-12); a previous study with a low-income sample of participants suggested that the HSQ-12 is a reliable, valid, and low-cost measure of health status (Barry, Kaiswer, & Atwood, 2007). Nonetheless, despite several participants in this study describing serious health conditions in group discussions (e.g., serious mental illness, addiction, frequent hospitalizations, physical disabilities, recent surgery, and cancer), over 90% rated their health to be good, very good, or excellent, while no one rated their health to be poor. Additionally, five participants reported that they were disabled and therefore could not work.

This discrepancy may suggest that the concept of health is relative, and interpretations of good health may be individually determined, thereby implying that this item is not a reliable indicator in a community such as Hartford, which suffers disproportionately from health inequities. Additionally, in this study, this item was included as part of the demographics survey, which was administered by me or a research assistant; thus social desirability may have impacted the validity of this measure. Participants may have been ashamed to admit poor health because it often carries a negative stigma. On the contrary, it is less likely that social desirability impacted these findings because the same participants that reported good overall health in the survey also self-described their symptoms and poor health status in group discussions. This contradiction suggests that fear of stigma may not have influenced participants' honest disclosure. Though commonly used in public health research (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006; Idler & Angel, 1990), the fact that this item was extracted from the broader scale may have impacted its validity. These findings point toward the need for additional mixed-

methods research to further investigate the validity of this self-reported measure of overall health.

### **Community Based Participatory Research**

This photovoice project engaged residents in Hartford in a community-based participatory research (CBPR) process of critical discussion regarding the intersection of place and health in the city. Like other photovoice studies, this participatory process engaged grassroots residents through picture-taking, critical reflection, and shared dialogue; findings reveled participants' conceptualization of health, their perceptions of the significant factors that impact health, and their recommendations for improving health in Hartford. Photovoice has been reinforced as an important methodology needed in order to expand beyond clinical models of care to broader, more relevant health interventions (Rigg, Cook, & Murphy, 2014).

Photovoice, by design, is anti-oppressive as it facilitates access to research for populations typically excluded from traditional knowledge-generating opportunities; the use of photography adds an artistic element that increases accessibility to broad stakeholders, including policy makers and health care providers, many of whom are often out of reach for marginalized communities (Chin, Sakamoto, & Bleuer, 2014; Delgado 2015). While photovoice is becoming more commonly cited in social work literature, recent studies primarily employ a critical, social constructionist or phenomenological lens to understand participants' experiences, rather than apply photovoice as a tool for social action (Capous-Desyllas & Forro, 2014; Harley, 2015; Jarldorn, 2015).

Reaching policy makers for the purposes of political advocacy is, however, one of the specified aims of photovoice, and this method has been considered a valuable instrument for community practice (Purcell, 2007; Wang & Burris, 1997). Additional research is needed to

better understand the impact of photovoice on policy change. Questions for further study include: How are photovoice results disseminated to major stakeholders (e.g., professionals, lawmakers, community leaders, other community members, etc.)? How do stakeholders perceive photovoice research? Does photovoice impact policy, and if so, how?

While this is not formally part of my dissertation, as I begin to disseminate the findings of this study with non-academic stakeholders in Hartford, I am considering how I may best impact policymakers. I have also begun to document this process by writing memos on my reflections and experiences with dissemination. As noted, I have created a dissemination team of participants who are interested in helping to share the results of this study with Hartford leaders and stakeholders. I am developing an action plan, a common output of CBPR studies. Its purpose is to summarize the findings of this study, including the key themes and specific recommendations of participants. Participants' pictures will be integrated for visual impact. After it is drafted, this report will be reviewed by participants on the dissemination team. Once it is finalized it will be shared electronically with my professional network and those who have requested a copy of the report. Members of the dissemination team and I are also willing to meet with others in Hartford who want to learn about the study, and we plan to present the findings to staff at the Hispanic Health Council. Finally, I intend to post the final report on the HHC website so that it is available publically.

**Trauma-informed framework.** Many participants in this study described that they themselves and/or others in their community are focused on the need to survive, and most reported a history of trauma. In some instances, participants noted that their survival sometimes meant that they needed to disconnect from their neighbors in order to maintain focus on their own personal well-being. Although an adaptive strategy that fostered self-preservation,

participants' ability to disconnect from others also seemingly detracted from their collective efficacy. It would be helpful to investigate further how a trauma-informed framework and/or a clinical strategies, which explicitly address coping with trauma in an urban context, might be integrated into future CBPR studies (East & Roll, 2015; Nelson, Price, & Zubrzycki, 2014). These perspectives are salient with both micro and macro social work practice and their integration into CBPR may enhance the conscientization and empowerment of photovoice participants, and thus also strengthen their shared understanding, trust, and collective efficacy.

**Human rights framework.** According to Article 25 of the Universal Declaration of Human Rights, everyone has the right to health (United Nations, 1948, p. 7):

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Eleanor Roosevelt, who chaired the committee which drafted this Declaration, suggested that human rights begin at home, in our neighborhoods, schools, and workplaces—the very spaces in which we grow, live, work and play (United Nations, n.d., para. 3). She noted:

Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world.

The conditions in which people live shape our experiences of the world, and our health, and as Roosevelt proposed, we must work to ensure that such conditions facilitate the right to health for everyone. Despite adopting the Universal Declaration, pervasive health inequities prove that the right to health is not yet a reality in the United States.

The vital importance of health was repeatedly emphasized in this study, and summarized best by Participant 27, who said:

*Health is everything. Without health you can't do anything at all. You can have a whole bunch of money, but you aren't going to be able to enjoy it. You aren't going to be able to enjoy being with your kids. You aren't going to be able to enjoy your job. Health is actually the main priority.*

This quote illuminates the often neglected human rights implications of health inequities. Not only is premature death attributed to health inequities a violation of human rights, but the elevated incidences of disease and disability surrounding illness in the United States further magnifies such infringements.

While social work incorporates a social justice perspective (National Association of Social Workers, 2008), it has not yet fully integrated a human rights framework. Doing so would challenge the profession's charitable approach to well-being and replace it with clear expectations that increase accountability. Libal and Harding (2015) argue the importance of carrying out human rights education in the community, so that marginalized, grassroots communities are equipped with the language and tools needed to mobilize for human rights. Moreover, Vos et al. (2009) posit that a right to health approach may augment organizing efforts with marginalized populations, and strengthen both the empowerment of clients and the effectiveness of policy change. Photovoice and other CBPR methodologies are particularly salient to these perspectives, and provide community practitioners unique opportunities to incorporate human rights into research and practice. Both human rights and CBPR are guided by the principles of participation, accessibility, equality, and empowerment (Libal & Harding, 2015; Wang et al., 1996). Yet, this is an underexplored area in the literature. Moving forward, when studying interventions to reduce place-based, health inequities, it would be useful to deliberately integrate a human rights framework into photovoice methodology, and assess its impact on social change.

## **Implications for Social Work Practice**

### **Professional Training**

Underlying participants' experiences with health care providers and teachers was a perceived lack of cultural humility and structural competency. Defined by Tervalon and Murray-Garcia (1998), cultural humility involves a "lifelong commitment to self-evaluation and critique, readdressing the power imbalances in the patient-provider dynamic, and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations" (p. 117). It is different from cultural competence in that it recognizes that despite having the best of intentions, human service professionals always will have room to grow in understanding the lived realities of other people, and it acknowledges power differentials inherent in the professional/client dynamic. Structural competency has been defined by Metzl (2012, p. 216) as:

The ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication 'non-compliance,' trauma, psychosis) also represent the downstream implications of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructure, medicalization, or even about the very definitions of illness and health.

This framework provides credence to the impact of social and economic factors on health and well-being, and it highlights that such factors are the result of deliberate policy decisions or the absence of policy. Structural competency emphasizes the need to integrate the social determinants of health into traditional models of health care intervention.

Training to enhance professional's cultural humility and structural competency may help to address participants' concerns with their care. Participants suggested that health care providers be more person-centered in their care, and value patients for the individual identities, strengths, and concerns, rather than simply stigmatize them with diagnoses and labels. Participants also suggested that medical providers often serve as gatekeepers to needed resources (e.g., social security disability) and that diagnoses (e.g., substance abuse) should not be an

excuse to deny a patient needed resources. Similarly, they suggested that teachers in Hartford schools be well trained to understand and address the ways in which poverty affects children's learning, and to employ a multicultural framework in engaging students and their families.

Public health social workers are well positioned to provide interprofessional training in cultural humility and structural competence. Social work education is grounded in a socio-ecological understanding of the person-environment fit. Social work education incorporates social justice values and oppression theory, which provides an ideological framework that can be used to develop training. Moreover, social workers are taught group work skills that are important for group facilitation. The findings of the health-related themes in this study could be useful in developing related training for professionals working in Hartford, Connecticut.

### **Public Health Interventions**

The specific recommendations to improve health that were part of this study's findings include innovative ideas that may be integrated to develop engaging interventions to improve health within the city. For example, access to healthy food was one major theme. Participants had a strong interest in community gardens, though most were confused about how to get involved with current gardening projects and about how to grow their own gardens. One participant stated that relying on land temporarily leased from the city to host gardens may not be sustainable, and may reduce the likelihood of local investment into that property; she suggested that personal gardens may be a more viable alternative. Thus, a comprehensive, community garden tool kit, which outlines specific guidance on how to grow produce may be a useful tool to encourage residents to grow their own food in their yards. Alternatively, participants suggested that perhaps some of the open space and/or abandoned properties in Hartford could be used for greenhouses that could grow food year-round, thereby implying that a sustainable, economic

system could be created to meet the demand for assessable, healthy and affordable food as well as needed jobs.

Additionally, participants highlighted the need for accessible, community-based after school programs for Hartford youth. Participants suggested that integrating art activities would make these programs more engaging. Many of their ideas to improve health and well-being could be also be integrated to create an innovative youth program. Perhaps some items discarded as litter could be reused as art supplies for creative art projects. Graffiti, a popular form of art in Hartford and other urban areas, could be supported to send pro-health messages to urban residents, in areas that have been approved by property owners for such artwork. Local artists could be hired to work with youth on such projects, and thereby serve as valuable role models. Students' community service requirement for school could also be used as a tool to leverage contributions from youth on projects that aim to improve the well-being of the community. In sum, the breadth of participant suggestions could be considered to guide the development of unique and practical programs.

Participants concerns about health in Hartford involved complex, integrated social problems. They suggested that in order to be effective, interventions to address these problems need to be multifaceted and integrative. Innovative interventions may then be evaluated for their direct impact on health (e.g., a community garden toolkit could be evaluated to assess its effect on food insecurity). Additionally, community-level interventions may be evaluated to assess their impact on collective efficacy; interventions that lead to improved collective efficacy may indirectly enhance community health (Dlugonski, Das, & Martin, 2015; Teig et al., 2009).

Social workers have unique assets that could support the development of these innovative interventions (Ohmer, 2010). Trained in ecosystems theory, social workers are taught to work



collaboratively and inter-professionally, with clients, communities, and institutions. They are well positioned to navigate the complex systems that would be necessary in developing sophisticated interventions, and would require participation from multiple stakeholders. Thus, social workers bring unique and valuable capacity to program development in health care, education, and social services.

### **Implications for Hartford**

The findings related to community perceptions of how Hartford may be improved are consistent with previous research and current discourse in the city. A 2012 community health needs assessment identified that food insecurity, poor quality and unaffordable housing, economic insecurity, community violence, and civic involvement were all concerns correlated with health inequities (Hartford Department of Health & Human Services, 2012). The eight health-related themes identified in this study parallel this assessment.

More recently, local residents have echoed participants' concerns at public meetings with elected officials. For example, at a town hall meeting earlier this year, a community resident asked Hartford's new mayor, Luke Bronin: "When you entered the 06112, could you hear it?... 'Could you hear the sound of poverty?'" (Stroller, 2016). Hartford residents discussed the need for the city to help create jobs for the unemployed, and to address the blighted, litter-filled, and overgrown properties which it owns. One resident described the city as her worst neighbor because it fails to maintain streetlights and public parks. Criticizing the previous mayor and the controversial baseball stadium development she said, "We have prostitution, we have drug dealing, we have people who set cars on fire."....'Maybe the last administration had hopes that we go to a baseball game and get over it'" (Stroller, 2016). These perspectives reinforce participants' concerns about poverty and its impact on quality of life.

## Political Context

This study is politically contextualized within the recent experience of the city of Hartford. For the last 15 years, residents have struggled to find effective public leadership. Mayor Eddie Perez, who served from December 2001 until June 2010, was popular among residents until he was forced to resign after a humiliating scandal that resulted in him being convicted of corruption charges (Flood, 2013; Pazniokas, 2015). Perez was the city's first "strong mayor;" he was the first to serve after the city adopted the strong mayor charter in 2002, which in essence shifted the role of mayor from symbolic figurehead to one with executive power (Hartford Courant, 2013). Mayor Perez was also the city's first Puerto Rican mayor, and was a source a pride for many in Hartford's large Latino community (Cohen, 2015a).

Perez' successor was, by default, the president of the Hartford City Council at the time of his resignation. Pedro Segarra became the city's second Puerto Rican and first openly gay mayor. He won reelection, but subsequently faced criticism for irresponsible use of city finances and poor leadership (Cohen, 2015b). Trained in social work and law, Segarra argued that he represented the people of the city, but he failed to make good on most of his promises to improve the city's economy, schools, and safety (Carlesso, 2015). He developed a reputation for being nice guy but an inadequate manager (Cohen, 2015b).

Many of the problems identified by study participants as contributing to poor health in Hartford (and that may undermine efforts at building collective efficacy) have long-standing roots. Indeed, despite their commitment to the city's most marginalized groups, both Perez and Segarra were largely unable to address chronic poverty, crime, inadequate housing, and the social exclusion of large segments of Hartford's population. Redevelopment investments that

may have little (direct) benefit for participants in this study—including a new minor league baseball stadium—were initiated during their respective administrations.

Then, in the fall of 2015, after a heated democratic primary Luke Bronin defeated Segarra, the five-year incumbent (Carlesso, Goode, & de la Torea, 2015). This was a particularly contentious race that fueled racial tensions in the city between the large constituencies of Black and Latino voters, particularly after the perceived failings of the two previous Puerto Rican mayors. Bronin, a thirty-six year old, White man from the wealthier, Fairfield County has been criticized for being an outsider to the city.

Bronin's successful mayoral bid was his debut at running for elected office (Carlesso et al., 2015). His top five priorities include economic development, to include but not be limited to the new stadium, jobs and youth employment, finances and budget, accountability and transparency, and public engagement (Carlesso, 2016a). In his campaign, Bronin also stressed the importance of arts and culture and his website outlined this interest in some detail. Vote Luke (2015) said:

*With so much to offer, Hartford needs a coordinated plan for arts and culture. Arts and culture can and should be a driver of economic development, and we need a mayor who can foster collaboration and offer support....Let's talk too about cultivating the arts talent of our youth, especially at a time when school art programs have been scaled back.*

Moreover, Mayor Bronin had been an outward critic of the previous administration's inadequate response to community violence (Carlesso et al., 2015). During his campaign, Bronin committed to creating safe streets and neighborhoods (Goode, 2016).

Though discourse involving political contexts did not evolve until the later stages of this study, Luke Bronin was a familiar face, showing up in participants' photos while campaigning for the democratic primary in the northern part of Hartford. He was photographed by more than

one participant while door knocking in neighborhoods and at community picnics. Participants noticed the attention he was giving residents by taking the time to talk with them.

Interestingly, since taking office in January 2016, Mayor Bronin has moved forward with initiatives that are not congruent with findings of this study. In an effort to decrease crime, he has committed to dramatically increase the police workforce (Goode, 2016). City residents and law enforcement leaders alike have critiqued this controversial approach that is sometimes considered a magical solution to reduce street crime (Dempsey, 2015). In this study, despite residents' pervasive concerns about safety and some participants' critiques of the efficacy of law enforcement in protecting the community, no one suggested that more police are needed in order to decrease violent crime. The participants clearly realized the traumatic effects of crime in their city; they shared countless personal stories involving drugs, violence, prostitution, guns, theft, and murder. Of particular concern to participants, was the well-being of young people in the city. While a concrete discussion about the size of the police department was not part of this study, participants suggested that in order to increase public safety, more resources should be allocated to fund programs that engage youth in safe, constructive activities, with role models that could provide support. They also suggested that art is a particularly important vehicle for relaying messages to the community and promoting well-being; examples included community concerts, a structured campaign using graffiti art to promote health-related messages, and after school programming, which integrates opportunities for youth to participate in art.

Unfortunately, contrary to his own campaign messages as well as the suggestions from participants, and amidst efforts to grow the city's police force in the context of a significant municipal budget shortfall, Mayor Bronin chose to cut arts funding and has not yet introduced any specific initiatives to support youth. He laid off Andres Chaparro, a key contributor to the

city's cultural affairs (Carlesso, 2016b). A Hartford-born, and internationally recognized artist, Chaparro has promoted art of various forms in the city for decades and is an advocate for artists in the city. He was the last of city hall staff members with job responsibilities involving art in Hartford. Seemingly, the decision to let Chaparro go was intended as an effort to strip non-essential amenities from the budget; perhaps however, this move suggests that Mayor Bronin may not be in tune with community residents' perceptions of what may be viewed as a superfluous investment.

Instead of delivering on campaign promises that were in tune with participants' concerns, Bronin is seeking legislative support for a controversial bill to implement a new, financial sustainability commission, which would essentially shift fiscal accountability from voter elected City Council members, to appointees who are only accountable to the mayor (Goode & de la Torre, 2016). In his first state of the city speech, Bronin criticized Hartford's former leaders for choices they made which have led to an expected \$30 million dollar debt as of 2017, something that Bronin called "a full-blown crisis" (Bronin, 2016). Using the same emotionally appealing jargon highlighted in the campaign, Bronin warned of painful decisions that are coming in his new city budget:

*There must be cuts in services and there will be layoffs. Difficult cuts that no one wants to make, and that in better times we wouldn't even contemplate. Cuts in services that are important. Not cutting fat, but sacrificing things that matter.* (Bronin, 2016)

Hartford Public Schools, as well as other city departments, are bracing for potential catastrophic cuts in services (de la Tóree, 2016). These will likely exacerbate the health-related concerns identified by participants in this study.

### **Stadium Development**

It is important to highlight the theme of community development in this study, and how it contrasts with the evolution of Hartford's newest project—Dunkin Donuts Stadium, home to the

minor league baseball team, the Hartford Yard Goats. The Yard Goats were previously based in New Britain, a neighboring city. Participants overwhelmingly perceived disconnect between investment in the stadium and residents' needs for improved access to affordable housing and healthy food. The \$56 million dollar stadium project was controversially approved by the previous administration in what has been criticized as a hurried process; the City Council approved financing for the development at a meeting that was held despite the city being shut down because of a major snow storm (Carlesso, 2015). Ironically, the land that houses the stadium was previously slated for a much needed, large-scale supermarket, which would have been only the second in the city and could have facilitated access to healthier food (Fowler, 2012; Ghosh, 2014; Reichard, 2014). Additional development initiatives for the land around the ballpark are also planned, and will contain housing and retail, including a grocery store. However, the grocery store will be small and will primarily target new residents of the development, not others living in the city's food desert neighborhoods; no funding was allocated in the budget to ensure that affordable housing units are part of the project (Carlesso & Gosselin, 2015; Gosselin, 2015).

In February 2016, the current City Council voted to spend another \$5.5 million due to cover higher stadium costs; Mayor Bronin negotiated the deal (Carlesso & Goode, 2016). An effort initiated by a Council member to ensure that the jobs at the stadium provide a living wage was voted down, because other Council members feared it could delay the project. The new administration seems to be in line with its predecessors in rushing to implement quick and expensive fixes, rather than thinking critically and collaboratively about such development decisions. Participants' skepticism about how the stadium will benefit local residents may be

justified as decisions regarding the project have thwarted opportunities to improve food security and provide well-paying jobs.

While it may be too early to tell, I fear that the direction that the city is headed in may support urban residents' widely shared perception and question that was asked by participants in this study: What is the value of my vote because, in essence, nothing improves anyway?

Moving forward, and in the context of a budget shortfall, it will be interesting to see how Mayor Bronin attends to his other key stated priorities, particularly his commitment to youth and public engagement, as these two issues are especially salient with the themes identified in this study.

Moreover, the themes of this study combined with the long-standing, dire political context, point to the need for stronger engagement of Hartford residents in political processes regarding decisions that directly affect their lives. Given the gravity of the health-related challenges facing residents in Connecticut's capital city, it is alarming that there is not a stronger social movement for government accountability. Consistent with reductions in available funding for grassroots organizing, agencies that once facilitated active community organizing efforts are struggling to survive (Goode & Carlesso, 2014) or, like the Hispanic Health Council, have focused their attention away from direct action. It is clear that health inequities, and the social conditions that they are rooted in, will likely never be resolved without targeted, community intervention.

### **Implications for Social Work Education**

With its distinct ethical value of social justice, the social work profession has a responsibility to help address this identified gap in community practice; it needs to explore novel, sustainable models for community organizing that can be used to facilitate change in struggling communities such as Hartford. Social work education has been critiqued in recent

years for not giving enough importance to macro practice (Rothman, 2013). The profession needs to strengthen the visibility of its roles as macro practitioners. Despite having shifted away from its community practice roots to a clinical focus, the profession of social work has a long history of training organizers (Fisher & Corciullo, 2011). With the current need for skilled organizers to facilitate change in isolated, urban communities like Hartford, there is considerable opportunity to bolster the profession's social justice impact. Local campaigns to decrease poverty and improve quality of life will undoubtedly also improve the health of city residents through the social determinants of health. In order to facilitate health equity, it is critical that social work educators better integrate specialized training in community organization into social work undergraduate and graduate curriculum and find ways to create and sustain paid organizing jobs for community practice social workers.

### **Conclusion**

Photovoice is a CBPR methodology that has potential to reduce health inequities; it is salient with social work's ethical values and its commitment to resolving social problems and improving well-being. This photovoice study engaged a sample of 24 residents from Hartford, Connecticut in a multistage project. Through the use of picture-taking and critical discussion, participants conceptualized health, identified their health-related priorities, and made recommendations to improve health. These recommendations may be applied to the development of innovative, health-related interventions, which could then be assessed for their impact on health.

Collective efficacy is a construct that is highly correlated with health. Defined as the willingness of people to intervene for the good of the community, it is composed of a neighborhood's social cohesion and its shared expectations of social control. While no changes



in participants' collective efficacy were observed during this study, methodological complexities made it difficult to accurately measure the impact of photovoice on collective efficacy. Further research is needed to address these limitations.

Finally, this study attempted to address gaps in the literature involving community practice social work and its ability to improve community health. Novel, comprehensive models of community invention that involve both the structural social determinants of health and social processes are urgently needed to address the root causes of health inequities. Social work is uniquely positioned to address this need. Therefore in order to remain true to its social justice mission, social work's responsibility and capacity to address the community-based, foundations of health inequities cannot be undermined.

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## Appendix A: Recruitment Flyer

Are you concerned about your health?  
Are you anxious about the safety of your neighborhood?  
Do you worry about the wellbeing of your family?  
Do you want to help make Hartford a better place to live?



- Do you live in Hartford?
- Are you 18 years old or older?
- Are you comfortable communicating in English?

If you answered YES ...  
**YOU MAY QUALIFY TO  
TAKE PART IN A  
SPECIAL RESEARCH  
PROJECT!**

- Participants will work together to identify ways to improve the places in which they live.
- Participants will take pictures to use as part of the research.
- This project will take place over the next year.
- Cameras and other project-related materials will be provided for free.
- Participants will be rewarded for their time.
- All meetings will take place at the Hispanic Health Council.
- Space is limited. Contact Karen D'Angelo for more information and to see if you qualify.

[illegible]

## Appendix B: Screening Form



**Screening Form**  
**Health in Hartford: A Photovoice Project**

Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Inclusion Criteria:** ALL Answers MUST Be YES.

- **Are you 18 years old or older?** ☐ Yes ☐ No
- **Are you currently a Hartford resident?** ☐ Yes ☐ No
  - How long have you lived in Hartford? \_\_\_\_\_
    - **Have you lived in Hartford for at least the past six months?** ☐ Yes ☐ No
- **Are you comfortable speaking English?**  
☐ Yes ☐ No

**Quota Sampling:**

- **What is your zip code?**
  - ☐ 06103
  - ☐ 06105
  - ☐ 06106
  - ☐ 06112
  - ☐ 06114
  - ☐ 06120
- **What is your gender?**
  - ☐ Male
  - ☐ Female
  - ☐ Transgender
- **What is your race/ethnicity?**
  - ☐ Black or African American
  - ☐ Asian
  - ☐ White
  - ☐ American Indian or Alaska Native
  - ☐ Native Hawaiian or Other Pacific Islander
  - ☐ Latino/Hispanic
  - ☐ Other: \_\_\_\_\_



## Appendix C: Informed Consent Form



### Informed Consent Form Health in Hartford: A Photovoice Project

#### Health in Hartford: A Photovoice Project

Principal Investigator (Lead Researcher): Scott Harding, PhD, MSW

Student Investigator (Doctoral Student): Karen D'Angelo, MSW

#### Purpose:

This study tries to 1.) Learn about what people living in Hartford think about where they live and its impact on the community's health; 2.) Find ways to improve living in Hartford in order to make it more healthy; and 3.) Develop a plan to share what we learn in this study. The goal of this project is to make Hartford a healthier place to live.

You are invited to take part in this study because you are a Hartford resident that is interested in using picture-taking to help improve the health of your community. In order to participate, you must have lived in Hartford for the past 6 months or longer, be 18 years old or older, and be comfortable speaking English.

#### Procedure:

This study will take one place over the next year. It includes 4 different stages, with several group meetings. You will be asked to take part in both group discussions and in taking pictures of your community. All group discussions will be tape recorded and put into writing.

- *Stage I: Focus Group (90 minutes)*
  - In a group with other participants, you will talk about the community that you live in and identify the strengths and challenges of Hartford as they relate to health.
- *Stage II: Photography (120 minutes of training plus picture taking)*
  - You will be trained in how to take pictures for this study.
  - You will take pictures of your community's strengths and concerns.
- *Stage III: Critical Dialogue (180 minutes)*
  - You will talk about your pictures with other participants, and as a group you will decide the biggest community concerns and which pictures best capture your concerns.
- *Stage IV: Critical Dialogue (180 minutes)*
  - Along with other participants, you will discuss what to do to improve these concerns.
  - You will help develop an action plan from what we learn from this project, which will help to make Hartford a healthier place to live.

Outside of these stages, you will be asked basic questions about your background. These questions will ask you about things like how much money you make, your relationship status, your job, your neighborhood, etc. You will also be asked to answer questions about your neighborhood before starting this project and after it is completed. After the study is done, you may be asked to work on the action plan.

In total, you will be asked to put in 12 hours of group activities. Outside of the group activities, you will take pictures on your own time. You will be asked to carry your camera with you and to take pictures throughout the course of your usual day, such as on your trip to work and home, while you visit your community park,

while buying food, etc. The picture-taking part of this project may take up to 5 hours of your time over the course of about a month.

I may contact you every so often in order to share or receive information about the study. You will only be contacted by phone or email at the number and/or email address that you give me. I will only leave a message if you say it is OK for me to do so.

**Voluntary Participation:**

Your participation in this study is completely voluntary, and you may choose to not answer any question(s). You have the right to leave this study at any time. You may stop taking part in this study at any time without punishment.

**Confidentiality:**

I will make every effort to maintain your privacy, but total confidentiality cannot be ensured. This is a group project that you will take part in along with other people in the community. While all participants will be asked to keep anything shared in the group completely private, there is some risk that others may share information outside of the group. The questions being asked of you are only for this study and your answers will not be shared with anyone in a way that would make it possible for anyone to know who you are. Every effort will be made to keep the information you share private.

You will be given a special number just for you. To help keep your privacy, this number will be used to identify you on forms and during group discussions, instead of your name. Only I will have access to the file that connects your name to your special number; it will be locked in a safe location.

For the purpose of safety, there are two specific times where your privacy may be broken by me. If, during this project, you share that you plan to hurt yourself, or someone else, I must report this to the proper authorities so that they may get involved and protect your safety and/or the safety of others.

All study records will be locked in a safe place. All tape recordings will be destroyed after the end of the study. All computer files with information that may identify you will be password protected. The computer account where such files are stored will also have password protection. Only I will have these passwords. Data that will be shared with others will not contain your name and/or information that may be used to identify who you are.

**Risks:**

Since we will be discussing the broad topic of health in Hartford, Connecticut, a range of issues might come up through the picture-taking and group discussions that may upset you. If this happens, I will offer you a break. Also, before the first focus group, all participants will be given an updated list of local resources that may be helpful to you.

**Benefits:**

Your participation may help to improve the health of Hartford residents. Also, you will be given a digital camera to use for this study and you will receive training in how to take pictures. If you complete all 4 stages of this study, you may keep this camera. You will also be given \$10 cash when you complete the Focus Group (Stage 1) and \$20 when you complete each critical dialogue (Stage 3 & Stage 4).

**Questions:**

If you have any questions about this study you can contact me, *Karen D'Angelo*, Student Investigator, at (860) 527-0856 X 267, or *Scott Harding*, Principal Investigator in charge of this study, at (860) 570-9182. If you

have questions about your rights as a participant, you may call *Laura Victoria Barrera*, member of the Institutional Review Board of the Hispanic Health Council, at (860) 424-4892.

**I HEREBY CERTIFY THAT I HAVE READ THIS CONSENT FORM, I UNDERSTAND ITS CONTENTS, AND AGREE TO PARTICIPATE IN THIS PROJECT.**

\_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Person  
Obtaining Consent**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

*If this consent form is read to the subject because the subject (or legally authorized representative) is unable to read the form, an impartial witness not affiliated with the research or investigator must be present for the consent and sign the following statement:*

**I confirm that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the subject (or the subject's legally authorized representative). The subject (or the subject's legally authorized representative) freely consented to be in the research study.**

\_\_\_\_\_  
**Impartial Witness Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

**I GIVE PERMISSION FOR YOU TO CONTACT ME REGARDING THIS STUDY BY WAY OF:**  
*(Check all that apply.)*

☐ **Home Phone:** \_\_\_\_\_  
(phone number)

May I leave a message on your answering machine and with someone who answers phone? ☐ Yes ☐ No

☐ **Cell Phone:** \_\_\_\_\_  
(phone number)

May I leave a message on your voicemail and with someone who answers phone? ☐ Yes ☐ No

☐ **Email Address:** \_\_\_\_\_  
(email address)

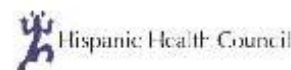
\_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

## Appendix D: Demographic Survey &amp; Collective Efficacy Pre-Test

1



### Health in Hartford: A Photovoice Project Demographic Survey

Participant ID: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for agreeing to participate in this study. The primary objectives of this project are to: 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy, and 3.) Develop an action plan to share the findings of our study with the broader goal of making Hartford a healthier place to live.

Before we begin, I'd like to ask you a few questions in order to learn more about you. I want to remind you that all information that you share is stored by participant ID number only, not by name, and that all data is kept confidential. I am the only person who will have a record of your ID number and this record will be kept in a locked storage cabinet and destroyed at the end of the study. If you have any questions about this survey, please do not hesitate to ask.

- 1.) **How old are you?** \_\_\_\_\_ age in years
- 2.) **How long have you lived in the United States?**  
\_\_\_\_\_ years \_\_\_\_\_ months
- 3.) **How long have you lived in Hartford, Connecticut?**  
\_\_\_\_\_ years \_\_\_\_\_ months
- 4.) **What is your gender?**
  - ☐ Male
  - ☐ Female
  - ☐ Transgender
  - ☐ Other: *Please specify:* \_\_\_\_\_
- 5.) **What language do you speak most often? (Please choose one).**
  - ☐ English
  - ☐ Spanish
  - ☐ English and Spanish Equally
  - ☐ Other: *Please specify:* \_\_\_\_\_

**(Turn Page Over)**

6.) What is your race / ethnicity? (Please choose all that apply).

☐ **Black or African American**

If you identify as Black or African American, are you...

- ☐ African American  
☐ Caribbean/West Indian : Please specify: \_\_\_\_\_  
☐ African : Please specify: \_\_\_\_\_  
☐ Other: Please specify: \_\_\_\_\_

☐ **Asian**

If you identify as Asian, are you...

- ☐ Asian Indian  
☐ Vietnamese  
☐ Lao  
☐ Cambodian  
☐ Chinese  
☐ Filipino  
☐ Korean  
☐ Other: Please specify: \_\_\_\_\_

☐ **White**

- ☐ Italian  
☐ Irish  
☐ Polish  
☐ English  
☐ German  
☐ Portuguese  
☐ Other: Please specify: \_\_\_\_\_

☐ **American Indian or Alaska Native** Please specify: \_\_\_\_\_

☐ **Native Hawaiian or Other Pacific Islander** Please specify: \_\_\_\_\_

☐ **Latino/Hispanic**

If you identify as Latino/Hispanic are you...

- ☐ Puerto Rican  
☐ South American: Please specify: \_\_\_\_\_  
☐ Mexican  
☐ Central American: Please specify: \_\_\_\_\_  
☐ Dominican  
☐ Cuban  
☐ Other: Please specify: \_\_\_\_\_

(Turn Page Over)

7.) In general, would you say that your health is...? *(Please choose one).*

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

8.) What is the highest level of school you've finished? *These are in terms of U.S. standards. If these standards are not familiar to you, please ask for clarification. (Please choose one).*

- ☐ No schooling
- ☐ Elementary School (grade 6 or less)
- ☐ Middle School (grade 7 or grade 8)
- ☐ Some High School (grades 9-12), no diploma
- ☐ High School Grad or GED
- ☐ Technical or Vocational School
- ☐ Some college
- ☐ Associates Degree
- ☐ B.A. or B.S.
- ☐ Graduate or Professional Degree
- ☐ Other: *Please specify:* \_\_\_\_\_
- ☐ Don't know

9.) In terms of relationship status are you currently...? *(Please choose one).*

- ☐ Single (never married, not living together)
- ☐ Married (not separated)
- ☐ Living together (not married)
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other: *Please specify:* \_\_\_\_\_

10.) Which of the following best describes your current employment situation? **This information is being asked for study-related purposes only and will not be shared with anyone.** *(Please choose all that apply).*

- ☐ Not employed or laid off
- ☐ Working full-time
- ☐ Working, part-time
- ☐ Student
- ☐ Other: *Please specify:* \_\_\_\_\_

***(Turn Page Over)***

11.) Including yourself, how many people live in your household?

\_\_\_\_\_

12.) How much is your monthly *household* income? (Please choose one).

- ☐ None
- ☐ Less than \$500
- ☐ \$500-\$999
- ☐ \$1,000-\$1,999
- ☐ \$2,000-\$3,999
- ☐ \$4,000-\$5,999
- ☐ \$6,000 or more
- ☐ Other: Please specify: \_\_\_\_\_
- ☐ Don't know

13.) Do you have health insurance? (Please choose one).

- ☐ Yes
- ☐ No (uninsured)
- ☐ Don't know

14.) What neighborhood do you live in? \_\_\_\_\_

15.) Why do you want to take part in this study?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Turn Page Over)

### Collective Efficacy Scale

The following questions ask you to think about the residents in the neighborhood in which you live. Please circle one response for each part of the question.

- 1.) How **LIKELY** is it that your **NEIGHBORS COULD BE COUNTED ON** to **TAKE ACTION** if:

- a. **Children were skipping school and hanging out on a street corner?**

1 Very Unlikely	2 Somewhat Unlikely	3 Neither Likely Nor Unlikely	4 Somewhat Likely	5 Very Likely	Don't Know
-----------------------	---------------------------	-------------------------------------	-------------------------	---------------------	---------------

- b. **Children were spray-painting graffiti on a local building?**

1 Very Unlikely	2 Somewhat Unlikely	3 Neither Likely Nor Unlikely	4 Somewhat Likely	5 Very Likely	Don't Know
-----------------------	---------------------------	-------------------------------------	-------------------------	---------------------	---------------

- c. **Children were showing disrespect to an adult?**

1 Very Unlikely	2 Somewhat Unlikely	3 Neither Likely Nor Unlikely	4 Somewhat Likely	5 Very Likely	Don't Know
-----------------------	---------------------------	-------------------------------------	-------------------------	---------------------	---------------

- d. **A fight broke out in front of their house?**

1 Very Unlikely	2 Somewhat Unlikely	3 Neither Likely Nor Unlikely	4 Somewhat Likely	5 Very Likely	Don't Know
-----------------------	---------------------------	-------------------------------------	-------------------------	---------------------	---------------

- e. **The fire station closest to home was threatened with budget cuts?**

1 Very Unlikely	2 Somewhat Unlikely	3 Neither Likely Nor Unlikely	4 Somewhat Likely	5 Very Likely	Don't Know
-----------------------	---------------------------	-------------------------------------	-------------------------	---------------------	---------------

*(Turn Page Over)*



Next, please tell us how much you AGREE with each of the following statements.  
Please circle one response for each question.

**2.) People around here are willing to help their neighbors.**

1 Disagree Strongly	2 Disagree Somewhat	3 Neither Agree Nor Disagree	4 Agree Somewhat	5 Agree Strongly	Don't Know
---------------------------	---------------------------	------------------------------------	------------------------	------------------------	---------------

**3.) This is a close-knit neighborhood.**

1 Disagree Strongly	2 Disagree Somewhat	3 Neither Agree Nor Disagree	4 Agree Somewhat	5 Agree Strongly	Don't Know
---------------------------	---------------------------	------------------------------------	------------------------	------------------------	---------------

**4.) People in this neighborhood can be trusted.**

1 Disagree Strongly	2 Disagree Somewhat	3 Neither Agree Nor Disagree	4 Agree Somewhat	5 Agree Strongly	Don't Know
---------------------------	---------------------------	------------------------------------	------------------------	------------------------	---------------

**5.) People in this neighborhood generally don't get along with each other.**

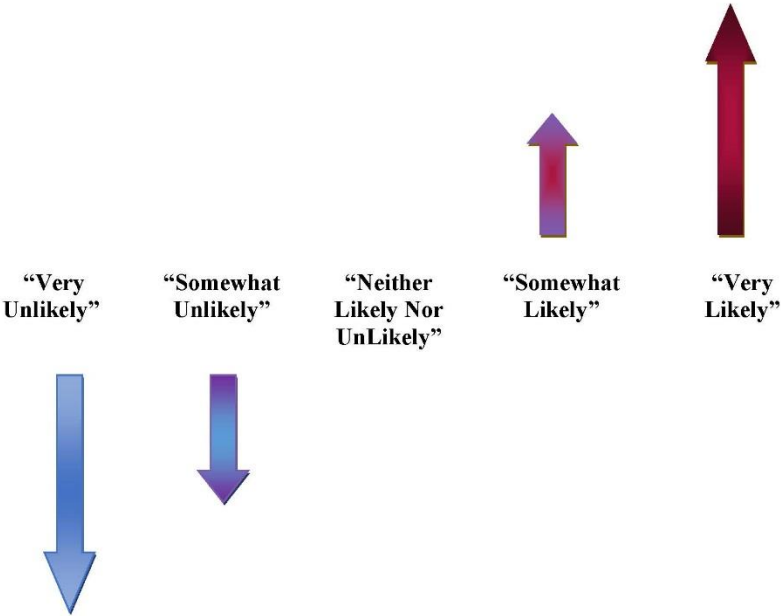
1 Disagree Strongly	2 Disagree Somewhat	3 Neither Agree Nor Disagree	4 Agree Somewhat	5 Agree Strongly	Don't Know
---------------------------	---------------------------	------------------------------------	------------------------	------------------------	---------------

**6.) People in this neighborhood do not share the same values.**

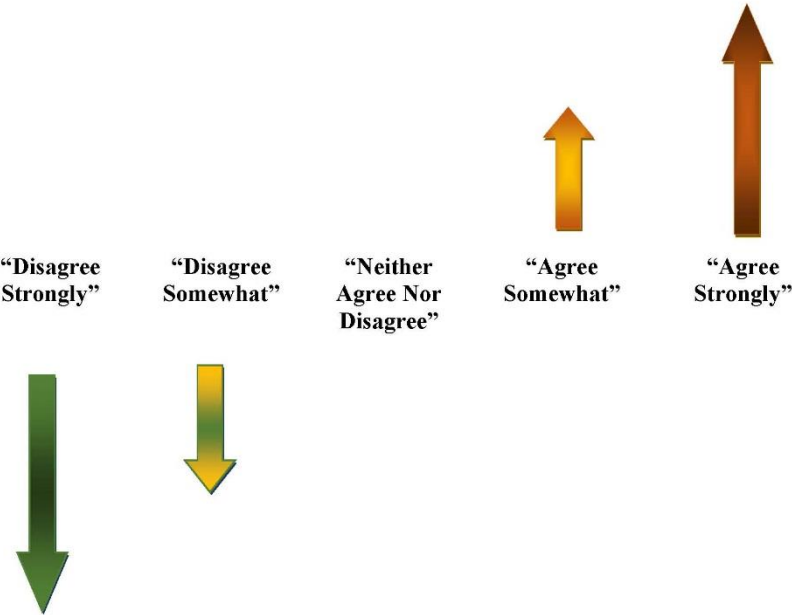
1 Disagree Strongly	2 Disagree Somewhat	3 Neither Agree Nor Disagree	4 Agree Somewhat	5 Agree Strongly	Don't Know
---------------------------	---------------------------	------------------------------------	------------------------	------------------------	---------------

**THANK YOU FOR COMPLETING THIS SURVEY!**

Cue Cards for Collective Efficacy Scale



Question 1



Questions 2-6

## Appendix E: Focus Group Semi-Structured Interview Guide



### Focus Group Semi-Structured Interview Guide Health in Hartford: A Photovoice Project

- 1.) To begin, I'd like to hear about the places in which you live. Describe your home.  
Describe your neighborhood. Describe the city of Hartford.
  - a. What is it like to live here?
  - b. What do you like most about living here?
  - c. What challenges do you face?
- 2.) What does "health" mean to you?
  - a. Do you define health as solely physical?
  - b. Are there Emotional, Mental, Spiritual domains to health?
  - c. Is health the absence of illness? Is health the state of complete wellbeing?
- 3.) In terms of where you live, how do you define your "community"?
- 4.) Thinking about the place in which you live, what advantages do you see that may help keep the community healthy? What barriers do you see that may make people sick?
- 5.) Do you think that the people who live in your community have a shared sense of responsibility of what happens in your neighborhood? Why or Why not?
  - a. Do people have a shared understanding of what to do if something goes wrong?
    - i. For example, can you count on your neighbors to take action if they witnessed children skipping school and hanging out on the street corner?
  - b. Can you count on your neighbors to take action if something threatens the safety of people in your neighborhood?
    - i. For example, if the budget for the local fire department becomes threatened, do you trust that your neighbors would come together to stop its closure?
- 6.) Do you think that people who live in your community are close? Why or why not?
  - a. Do neighbors share the same values? Can you provide an example?
  - b. Are people willing to help each other in your neighborhood? How or how not?
- 7.) Can you think of any examples of how people in your community are working together to make it a better place to live?
- 8.) Finally, what would you identify as the most pressing concerns that you have about where you live?
  - a. Do you think these concerns affect *your* health? If so, in what ways?
  - b. Do you think these concerns affect the health of your community? If so, in what ways?

## Appendix F: Resource List



### Resource List Health in Hartford: A Photovoice Project

- **211**  
**United Way of Connecticut**
  - Phone-based, information line which provides referrals to local services in the community. If you or someone you know needs help, 211 can help direct you for assistance.
  - Highly-trained call specialists help callers find assistance for a range of complex issues which include financial problems, housing assistance, childcare providers, healthcare, utility support, and suicide prevention.
  - May be dialed from anywhere in Connecticut, 24-hours a day, every day of the year. Multilingual assistance and TDD access is also available.
  - Phone Number: 211
  - Website: <http://www.ctunitedway.org/>
- **Connecticut Center for Prevention, Wellness, and Recovery**  
**Connecticut Clearinghouse**
  - Statewide library and resource center for information on substance use and mental health disorders, prevention and health promotion, treatment and recovery, wellness and other related topics.
  - Online resources available in multiple languages.
  - Online information about local behavioral health resources.
  - Online screening tools available for free.
  - Anyone who is a Connecticut resident is eligible to be a member.
  - Members may access library resources from their Plainville location at no charge.
  - Phone Number: 1-800-232-4424
  - Website: <https://www.ctclearinghouse.org/Default.asp>
- **Connecticut Department of Mental Health & Addiction Services**  
**Community Information and Crises Hotlines**
  - State agency responsible for administering comprehensive, recovery-oriented behavioral health services.
  - Serves all areas of Connecticut; Hartford is included in Region 4.
  - Offers referrals to mental health and addiction services.
  - Community Call Line: 860-418-6962
  - Adult Crisis Line (24-hour): (860) 297-0999
  - Child Crisis Line (24-hour): 211
  - Website: <http://www.ct.gov/dmhas/site/default.asp>

## Resource List

### Health in Hartford: A Photovoice Project

- **Connecticut Department of Social Services  
Benefits Center**

- State agency which is responsible for delivering a wide variety of services to children, families, adults, people with disabilities and the elderly, including healthcare coverage, child care, child support, long-term care and supports, energy assistance, and food and nutrition aid.
- Receives applications for food assistance (SNAP/Food Stamps), healthcare (Husky/Medicaid), and cash assistance (TANF/Welfare). Applications may be submitted online.
- Anytime, Automated Phone Number:  
1-855-6-CONNECT (1-855-626-6632)
  - Benefits Center Staff may be reached via this number Monday through Friday, between 7:30am and 4:30pm.
- Website: <http://www.ct.gov/dss/site/default.asp>

- **Greater Hartford Legal Aid**

- Represents low-income people in court, at administrative hearings, and before government agencies and the legislature. Protects the legal rights of those living in poverty and advocates for pragmatic, fair solutions to the problems they face. Also provides community legal education to help people advocate for themselves.
- Addresses a variety of individual, legal issues pertaining to children, employment, people living with a disability, families, government benefits, HIV/AIDS, housing, immigration, and seniors.
- Website also contains a number of self-help guides.
- Phone Number: 860-344-0380
- Website: <http://www.ghla.org/>

- **Hartford Public Library**

- Free services for Hartford residents targeting children, youth, and adults. Services include, but are not limited to, job training, courses for new immigrants, tax preparation, passes to local museums, literacy support, assistance in preparing for the GED, voting information, and resume building and networking support.
- Website offers additional resources for ex-offenders and access to healthcare.
- 10 different branches across the city.
- Phone Number: 860-695-6300
- Website: <http://www.hplct.org/>

## Appendix G: Photography Training

# Health in Hartford! A Photovoice Project

## Phase II: Photography



KAREN D'ANGELO  
JULY 24, 2015



## Welcome Back!

- ▶ Thanks for joining us!
- ▶ This is the second part of a 4-stage research project.
- ▶ Today, we will:
  - ▶ Discuss what "Photovoice" is and why we are doing this project;
  - ▶ Give you directions for picture-taking;
  - ▶ Provide you with some basic training on how to use the camera.
- ▶ I will give you each a camera and we can practice using it.
- ▶ What kind of responsibility do we have when we carry around a camera to document our lived experiences in our community?



## Photovoice –What is it?

- ▶ Participants use picture-taking as a way to record their lived experiences. Pictures can have a very powerful message and impact.
- ▶ Participants then meet to discuss what is happening in the pictures.
- ▶ Based on these discussions, participants identify goals for social change in their communities.

Today, you will receive a camera. You are asked to use that camera to take photos in your community. In the next two stages of this study, you will be part of the decision-making process in how the photos and stories will be shared.

## Safety Concerns

- ▶ **Shoot Smart**—Use your street smarts. Give careful thought to the context and content of your photos, along with your personal safety.
- ▶ Do not trespass on privately owned property.
- ▶ Respect the privacy of others. If someone does not wish to be photographed, respect his/her choice.
- ▶ What would you not want to be photographed doing?
- ▶ Do NOT take anyone's photo who you suspect may be taking part in illegal behavior, such as drug use, or theft. Do NOT take anyone's photo who is participating in embarrassing behavior. These situations could put the community members portrayed in the pictures and you in possible danger.

## Guidelines for Picture-Taking

- ▶ Pictures must be taken within the city of Hartford, Connecticut.
- ▶ Pictures may include people, but do NOT need to include people. Think creatively about how you may represent your ideas in abstract ways.
- ▶ Pictures may be taken inside or outside.
- ▶ Unless you have specific permission to photograph in someone's private space, focus your picture-taking in public areas.
- ▶ What is a good way to approach someone when you wish to photograph him/her?

## HIH Photovoice Project Information Sheet

- ▶ If taking someone's picture, introduce yourself, clearly explain why you are taking pictures, and ask permission to photograph someone before taking his or her picture.
  - ▶ "Hi! My name is \_\_\_\_."
  - ▶ "I am participating in a research project with other Hartford residents. I am taking pictures of my community to help identify health concerns and benefits here in our city. I would like to take your (or your child's picture) picture as part of this project. Would that be OK with you? Do you have any questions?"
  - ▶ Hand the individual the "HIH Photovoice Project" information sheet, and answer any questions that he or she may have.



## Photo Consent Form

- ▶ Each adult photographed needs to complete the "Photo Consent Form" in order for his/her picture to be used in this project. Parents/guardians may include their children in their same consent form. Ask each community member to sign two copies. You keep one copy which gets returned to me, and they keep a copy.
- ▶ Review "Consent to Use Photographs" with each person whom you may photograph. Only consent those who you can easily communicate with. Explain what this means and answer all questions to the best of your ability.
- ▶ If minors under the age of 18 are photographed, their parent or legal guardian must sign the "Photo Consent Form" on their behalf. One "Photo Consent Form" should be completed per child. Additionally, if children do not want to be photographed, then their decision should be respected.
- ▶ Ensure that all information is carefully filled out on form. Forms must be complete. Contact information is only kept in order to reach the community member if there are any questions about his/her consent to be photographed.
- ▶ Complete the Photographer's section of the Photo Consent Form. Be sure to give the community member a signed copy of the form, and check off the box to note that you have done so.
- ▶ Keep careful track of all completed Photo Consent Forms. They must be returned to me with your pictures. Pictures of people who are identifiable will not be able to be used unless you submit a signed and completed "Photo Consent Form".

## Let's Practice

- ▶ Pair participants.
- ▶ Ask one to play the role of the HIH study photographer.
- ▶ Ask one to play the role of the community member.
- ▶ Practice introducing the study, sharing the Information Sheet, and administering the Photo Consent Form.
- ▶ Ask participants to switch roles and repeat the exercise.

## Content of Pictures

- ▶ Thinking about the place you live, what advantages or benefits do you see that help to keep people healthy? What challenges do people face that lead them to getting sick?
- ▶ Based on focus group discussions, components of health may include:
  - ▶ Physical illness or pain
  - ▶ Access to quality health care services, including check-ups
  - ▶ Mental health
  - ▶ Spirituality
  - ▶ Healthy lifestyles
  - ▶ Coping with worry and stress
  - ▶ Desire to grow and learn
  - ▶ Social support

## Content of Pictures—Advantages or Benefits

- ▶ **Thinking about the place you live, what advantages or benefits do you see that help to keep people healthy?**
- ▶ Suggested topics to consider, based on feedback from the focus group discussions:
 

<ul style="list-style-type: none"> <li>• Art</li> <li>• Fun things to do</li> <li>• Supportive housing services</li> <li>• Social service resources</li> <li>• People currently working to create change in Hartford</li> <li>• Health care in the community (community vans)</li> </ul>	<ul style="list-style-type: none"> <li>• Beautiful city</li> <li>• Green space</li> <li>• Clean neighborhoods</li> <li>• Diversity</li> <li>• Capital city</li> <li>• It's easy to get around</li> <li>• Neighbors watching out for each other</li> <li>• Strong schools</li> </ul>
--	---

## Content of Pictures—Challenges

- ▶ **Thinking about the place that you live, what challenges do people face that lead them to getting sick?**
- ▶ Suggested topics to consider, based on feedback from the focus group discussions:
  - Quality of life concerns
  - Substance abuse
  - Housing
  - Violence
  - Government corruption
  - Cost of living
  - Food
  - Children and youth
  - Health care
  - Need for more good jobs
  - Need to work together
  - Need for additional cultural activities
- ▶ If you are concerned about the well-being of a community member and it is not an emergency, it is best to refer that person to Hispanic Health Council and/or refer the person to call 211. Both resources will help direct the person towards help.

## Informed Consent Form

- ▶ Please review the form  
**“Stage II Photography: Informed Consent Form”**
  - ▶ This form outlines our agreement about what is being expected of you during this next phase of the project.
  - ▶ Since this is a collective project, decisions about how to use photos will be decided as a group in later stages of this project.
  - ▶ If any money is received from the sale of any print or digital image, that money will put towards Health in Hartford activities that will directly benefit the Hartford community.
  - ▶ You will be able to keep a digital copy of the pictures you take in this study. It is very important however that you respect the privacy of the people you have photographed.
- ▶ Do you have any questions?
- ▶ If you wish to take part in Stage II, please sign this form.
- ▶ Each person who signs consent form is given a digital camera.
  - ▶ Reminder: Only those who complete the study may keep this digital camera.

## Camera Basics

### Turning the Camera On and Off

- ▶ Press the power switch to turn on the camera.
- ▶ Hold down the same button to turn it off.

### Taking a Picture!

- ▶ Hold the camera steady.
- ▶ Press the shutter button half way to focus.
- ▶ Then press it all the way to take the picture.

### Reviewing Images

- ▶ Press the playback button, and your pictures will appear.
- ▶ Refer to image to see how to navigate through pictures.
- ▶ To go back to the home screen, press the "SCENE" button.

## Camera Basics (Cont.)

### Deleting Images

- ▶ Press the trash button.
- ▶ Select from the options: Current image; Erase selected images; All images.
- ▶ Select Yes.

### Zooming in and out

- ▶ Move the zoom control to activate it.
- ▶ Rotate the zoom control towards the "W" to zoom out.
- ▶ Rotate the zoom control towards the "T" to zoom in.

## Camera Basics (Cont.)

### Inserting the Batteries

- ▶ Open the battery/memory card slot
- ▶ Insert the batteries.
- ▶ Close the battery slot.
- **Make sure the camera is OFF \***

### Inserting the Memory card


- ▶ Open the battery/memory card slot
- ▶ Insert the memory card.
- ▶ Close the battery/memory card slot.
- \* **Make sure the camera is OFF \***

## Timeline

- ▶ Spend the next 2 weeks taking photographs.
- ▶ You are asked to contribute a total of 30 photographs for this study. You may take more pictures, but will need to limit the number that you give to me to 30. (I can help you limit these pictures if you would like).
- ▶ Contact me by **August 7<sup>th</sup>** to schedule a time for me to copy and review your pictures.
  - ▶ Contact Info: **Karen D'Angelo**  
**860.527.0856 X 267 (office) or 203.640.7473 (cell)**  
**Karen.D'Angelo@uconn.edu**
- ▶ Return all completed Photo Consent Forms so that we may match the forms with your pictures.





## Appendix H: Information Sheet




## HEALTH IN HARTFORD! A PHOTOVOICE PROJECT

I am a participant in the project Health in Hartford! I'm taking pictures in my community to help identify health problems and / or benefits in our city. This project includes other Hartford residents who are taking pictures like me. We will use these images to see if we can identify ways to improve the area where we live. If you agree, your photo can be publicly shared in presentations or in the media to demonstrate the needs of our community. It is required to sign a form giving us permission to take your picture and use it in the study. Your name will not appear in the photo. This form requires your contact information. We will use it only if we have questions about your participation. Please call Karen D'Angelo at 860-527-0856 extension 267 for more information or questions. Thank You!!





Hispanic Health Council





## SALUD EN HARTFORD! UN PROYECTO DE FOTOVOZ

Soy un participante del Proyecto Salud en Hartford! Estoy tomando fotos de mi comunidad para ayudar a identificar problemas sobre la salud y/ó los beneficios en nuestra ciudad. Este proyecto incluye otros residentes de Hartford que están tomando fotos como yo. Pensamos utilizar estas imágenes para ver si podemos identificar maneras de mejorar el área donde vivimos. Si usted está de acuerdo, su foto puede ser compartida públicamente en presentaciones o en los medios de comunicación para demostrar las necesidades de nuestra comunidad. Se requiere que nos firme una forma dándonos permiso a tomarle la foto para utilizarla en el estudio. Su nombre no aparecerá en la foto. Esta forma requiere su información de contacto, que solo usaremos si tenemos preguntas sobre su participación. Favor de llamar a Karen D'Angelo al 860-527-0856 extensión 267 para más información ó preguntas. ¡¡Gracias!!




Hispanic Health Council



## Appendix I: Photo Consent Form



**Photo Consent Form**  
**Health in Hartford: A Photovoice Project**

**Consent to Use Photograph(s):**

*I \_\_\_\_\_ agree to have my and/or my child(ren) \_\_\_\_\_'s picture taken as part of the Health in Hartford research project. I confirm that I am adult at least 18 years of age, and that I am the legal guardian of the child(ren) named above (if applicable). I understand that the photos may be used as part of this project in order to advocate for ways to make Hartford an even better place to live. I agree that the pictures may be shared publically for such purposes. I understand that my and/or my child's name will not be publically shared with regards to this study. I understand that I will not be able to inspect or approve my and/or my child's pictures. I agree that the pictures shall remain the property of the researcher, Karen D'Angelo, and of the community participants in this study. I also understand that the community participants in this study (e.g. those who are taking pictures) may also keep a copy of the pictures. I give to Karen D'Angelo, unlimited permission to copyright and use photographs that may include me and/or my child.*

Name(s) of person(s) photographed (please print)		
Name of Adult in Picture		Age
Name of Minor (if applicable)	Relationship to Minor	Age of Minor
Name of Minor (if applicable)	Relationship to Minor	Age of Minor
Name of Minor (if applicable)	Relationship to Minor	Age of Minor
Signature: _____		Date: _____
Name (Please print): _____		Phone: _____

Photographer's name: _____
Signature: _____ Date: _____ Location: _____
<input type="checkbox"/> Ask the person in the photograph to complete two forms and keep one signed copy. Check this box to confirm that you have done this. Give the second signed copy to Karen D'Angelo.
Karen D'Angelo, Hispanic Health Council, 175 Main St., Hartford, CT 06106. 860.527.0856 X 267. KarenD@hispanichelath.com

## Forma de Consentimiento para Fotografías Salud en Hartford: Un Proyecto de Foto Voz

**Consentimiento para usar su(s) foto(s):**

Yo \_\_\_\_\_ estoy de acuerdo que tomen mi foto o la de mi(s) hijo(s) \_\_\_\_\_ como parte del proyecto de investigación Salud en Hartford. Confirmando que soy un adulto de al menos 18 años de edad y que soy en guardián legal del menor indicado arriba. Entiendo que las fotos puedan ser usadas como parte de este proyecto para abogar que Hartford sea un mejor lugar para vivir. Estoy de acuerdo de que mi foto o la de mis hijo(s) puedan ser compartidas públicamente para estos propósitos. Entiendo que mi nombre o el nombre de mi(s) hijo(s) no serán compartidos públicamente en relación a este proyecto. Entiendo que no podré inspeccionar o aprobar las fotos una vez sean tomadas. Estoy de acuerdo de que mi foto o la de mis hijo(s) serán propiedad de la investigadora, Karen D'Angelo, y los participantes comunitarios de este proyecto. También entiendo que los participantes comunitarios de este proyecto (p. e.j. aquellos que están tomando fotos) pueden mantener copias de las fotos. Le doy a Karen D'Angelo permiso ilimitado para hacer copias y usar las fotos que tal vez me incluyan a mí/o a mis hijos.

Nombre(s) de la persona(s) fotografiada (letra de molde)		
Nombre del adulto en la foto		Edad
Nombre del menor (si aplica)	Relación con el menor	Edad del menor
Nombre del menor (si aplica)	Relación con el menor	Edad del menor
Nombre del menor (si aplica)	Relación con el menor	Edad del menor
Firma: _____	Fecha: _____	
Nombre (si aplica): _____	Teléfono: _____	

Nombre del fotógrafo: _____
Firma: _____ Fecha: _____ Ubicación: _____
<input type="checkbox"/> Pídale a la persona en la foto que complete dos formas y que retenga una copia firmada. Marque esta casilla para confirmar que ha hecho esto. Entregue la segunda forma firmada a Karen D'Angelo. <div style="text-align: center; margin-top: 10px;">             Karen D'Angelo, Hispanic Health Council, 175 Main St., Hartford, CT 06106.              860.527.0856 X 267. KarenD@hispanichelath.com           </div>



## Appendix J: Photography Informed Consent Form



### Stage II Photography: Informed Consent Form Health in Hartford: A Photovoice Project

#### Purpose:

This study uses picture-taking to 1.) Learn about what people living in Hartford think about where they live and its impact on the community's health; 2.) Find ways to improve living in Hartford in order to make it more healthy; and 3.) Develop a plan to share what we learn in this study. The goal of this project is to make Hartford a healthier place to live.

#### Guidelines:

As a participant in the Health in Hartford Study Photography Stage, you will receive a digital camera in which to record your experience living in Hartford. By signing this form, you agree with the following:

- You have received training in photography and understand the potential risks of picture-taking in the community. Potential risks may include upsetting other community members who may not wish to have their pictures taken, which may place you in a threatening position.
- You agree to NOT take anyone's picture who you suspect may be taking part in illegal behavior (such as drug use), or who you suspect may be embarrassed by the picture. Pictures where this may be the case will not be used in this study. Photographing in such situations may also put you in danger.
- If you take anyone's picture who may be identified based on how they look, you must receive written permission to do so. Unless his or her face is not recognizable in the picture (for example, if you are taking the shot from very far away), you must have each person in each photo complete and sign a "Photo Consent Form." Pictures of people without a complete "Photo Consent Form" will not be used for this project. If you take a picture of anyone under the age of 18, you must also have the minor's legal parent or guardian sign a "Photo Consent Form" for the child.
- You agree to share the pictures that you take with Karen D'Angelo, student researcher, for use in this study. Together, participants will decide how to best use the pictures in the later stages of this study. You also agree to allow your photographs to be shared with regards to this study in academic settings and/or local media and presentations.
- You may also keep a digital copy of your photographs. It is very important that you respect the privacy of the people in the pictures. Be careful of where you may share pictures of community members. For example, it would not be appropriate and could even be dangerous to share a picture of someone else on social media such as Facebook.
- Any proceeds obtained through the sale of images or prints will be put towards project activities that will directly benefit the Hartford community.
- You may remain anonymous as part of this study and your identity will not be publically revealed with regards to your photographs. However, before taking pictures of others, you must introduce yourself using your first and last name; your name will also appear on the *Photo Consent Form* that you give to the people in your photos.

As a reminder, your participation in this study is completely voluntary and you have the right to stop taking part at any time. While there will be no penalty if you choose to stop participating, you may only keep the camera if you complete all four stages of the study.

**Questions:**

As always, if you have any questions about this study you can contact *Karen D'Angelo*, Student Investigator, at (860) 527-0856 X 267, or *Scott Harding*, Principal Investigator in charge of this study, at (860) 570-9182. If you have questions about your rights as a participant, you may call *Laura Victoria Barrera*, member of the Institutional Review Board of the Hispanic Health Council, at (860) 424-4892.

**I HEREBY CERTIFY THAT I HAVE READ THIS CONSENT FORM, I UNDERSTAND ITS CONTENTS, AND AGREE TO PARTICIPATE IN THIS PROJECT.**

\_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Person  
 Obtaining Consent**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

*If this consent form is read to the subject because the subject (or legally authorized representative) is unable to read the form, an impartial witness not affiliated with the research or investigator must be present for the consent and sign the following statement:*

**I confirm that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the subject (or the subject's legally authorized representative). The subject (or the subject's legally authorized representative) freely consented to be in the research study.**

\_\_\_\_\_  
**Impartial Witness Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

\_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

Appendix K: Facilitator's Guide—First Critical Dialogue

Health in Hartford Photovoice Study

# Facilitator's Guide First Critical Dialogue

Stage III

November 7, 2015

**Lead Facilitator:** Karen D'Angelo, MSW

**Small Group Facilitators:** Doctoral students and recent graduates from UConn School of Social Work, along with undergraduates from UConn will be small group facilitators; all will have received CITI certification documenting that they have received training in human subjects social and behavioral research.

Facilitator Contact Information:

Name	Email	Cell
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX

**Participants:** Health in Hartford Photovoice Study Participants

**Small Groups:** Small groups of 3-4 Health in Hartford study participants will be formed based on zip code. Groups will be labeled by color. This color marker will be used when writing notes on flip chart pages. This color will also be used to label pictures with numbers. Colors may include red, green, blue, purple, black, and orange.

**Date:** Saturday, November 7, 2015

**Meeting Time:** 9:00am

**Start Time:** 9:30am-12pm

**Location:** Hispanic Health Council, 175 Main Street, Hartford, Connecticut

**Goal:** The goal is to make Hartford a healthier place to live. The objectives of this study are to 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy; and 3.) Develop an action plan to share the findings of this study.

**In this third phase of the Health in Hartford study, participants will view their photographs and reflect on their deeper meaning. Small group discussion will be used to process photographs and identify key priorities which will be shared with the broader group in the large group discussion.**

**Resources:**

- Printed 4”X6” pictures that are labeled with ID number on back
- ShOWED Worksheet (5 per small group)
- Pens (6 per group)
- Flip Chart pages to tally photos (with chart already drawn)

Photo ID #	# Votes
[List all photos here]	[tally number of votes]

- Flip Chart pages to matte photos (6 per group)
- Markers (1 color per group)
- Note pad for the facilitator (1 per group)
- Digital recorder (1 per group)
- Table and chairs for each small group
- Copies of resource list to be made available upon request
- Copies of informed consent form for study available upon request
- Breakfast foods
- \$20 in an envelope for each participant
- Sign in list with phone numbers (so they may be updated)

**Timeline:** *Facilitators—please arrive at HHC before 9am; at 9am sharp we will review facilitation protocols.*

Time	Activity	“Staff”
9:30am	-Participants will arrive at Hispanic Health Council. -Participants will be checked-in and invited to grab breakfast. -Participants will be escorted to their tables. -Facilitators will be waiting at tables. -Once participants arrive, participants will be invited to take part in ShOWED Free-Write Activity.	-Karen will greet participants, sign participants in, verify contact information and distribute name tags -Small group facilitators will be at tables
10:00am	Participants will share what picture(s) they identified and the reasons why they chose the picture. Participant will discuss the photos.	Small group facilitators; Karen will float to troubleshoot.
10:30am	Prioritizing pictures based on nominal process (voting)	Small group facilitators; Karen will float to troubleshoot.
10:40am	Pictures will be matted and summarized on flip chart paper.	Small group facilitators; Karen will float to troubleshoot.
11:00am	Break	
11:10am	Large Group Discussion	Karen will facilitate; Staff will take notes
11:55am	Wrap Up; Next Steps; Disseminate Incentive	Karen and Staff

### Small Group Facilitation

- Pictures will be laid out on your work station.
- As participants come in, invite them to review the photos and choose one picture that stands out to them.
  - If a person is interested in a picture that someone else has chosen, please remind them that we will all be reviewing the pictures together, and each person will be given the opportunity to review the photos.
  - Also, it does not matter which participant took the photo(s). All photos were taken by HHH participants, but at this point in the process, we are working collectively so it is not important that participants focus on the photo(s) they took as part of the project. (We are actually aiming to decrease individual ownership at this point and are trying to encourage collective reflection as part of the critical consciousness building process.) If applicable, please try to discourage participants from focusing on the photos that they personally took and to instead explore the entire display of the photos.
- Provide each participant with the ShOWED worksheet and a pen; ask him/her to reflect on the photo chosen and to complete the worksheet. Participants are asked to freely respond to the questions in writing. If the person completes this for one photo, he or she may choose two to four more and he or she is invited to repeat the process for each photo. **The goal is for each participant to have individually chosen 3-5 pictures that stand out to him/her with regards to health in Hartford.**
  - On each worksheet, please be sure each participant lists his/her participant ID number. (This is the number assigned to him/her for the study and will be printed on name tag.) Please also be sure the picture number is noted on the worksheet. The worksheet asks participants: 1) What do you SEE here? 2) What's really HAPPENING here? 3) How does this relate to OUR lives? 4) Why does this problem, concern, or strength EXIST? And 5) What can we DO about it?
- Karen will inform you when all group members have arrived.
- **At this point, please turn on digital recorder.**
- Once all group members have arrived and have had a chance to participate in a freewrite, please review the purpose of today's session with the group.
  - *"This is the First Critical Dialogue; it's the third phase of our project. As you may recall, the main objectives of this study are to: 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy; and 3.) Develop an action plan to share the findings of this study with the broader goal of making Hartford a healthier place to live.*
  - *Today, we are going to begin by working in small groups. Our goal in this session is to review the pictures that you took in Stage II, and work together to identify which pictures really stand out to us regarding health in Hartford, and what issues are most important to us as a group. The next and final time we meet,*

*we will build on today's conversation to identify our shared priorities for change, in order to make Hartford a healthier and even better place to live."*

- Please also review the guidelines for the day:
  - *"Confidentiality is very important. We are using our assigned numbers instead of names, so that we can keep our discussions as anonymous as possible. As a reminder, let's agree to not share anything that anyone says outside of this room; that way we create a safe space for people to openly talk.*
  - *The pictures that we are reviewing were all taken by Health in Hartford participants. It does not matter who took which pictures, and it is OK if you are reviewing pictures taken by someone else rather than your own.*
  - *Because we are talking about concerns regarding the places in which we live, some of us may experience emotional reactions or become upset. If you are upset, you are welcome to take a break at any time. Also, if you need to talk with someone, please let Karen or your small group facilitator know. Karen has a list of resources that are also available if you want a copy. (These are the same resources that were given to each of you when you attended the focus group or when you signed-up for the study)*
  - *Participation in this study is completely voluntary and you are free to leave at any time without any negative consequence. However, only those who stay for the entire dialogue (no more than 3 hours) will be entitled to the \$20 compensation at the end."*
  - Please answer any questions participant may have; direct any questions that you cannot answer to Karen.
- Invite participants to share with the small group the pictures that they chose and the reasons for why they chose the picture; they should be summarizing the SHOWED reflection for each photo.
  - Example: I chose this photo of \_\_\_\_\_. What I see here is \_\_\_\_\_. I think it exists because of \_\_\_\_\_.

Please take notes as best as possible during this process. (If you feel that you cannot adequately balance notetaking and facilitation, please prioritize the facilitation).

- Go around the group until each person has shared his/her pictures. Thus, approximately 9 and 20 photos should have been shared with the group.
- After all participants have presented their photos, the discussion will be opened to the entire group. Prompts to facilitate discussion:
  - *What are your reactions to these photos?*
  - *Which photo(s) stood out to you most?*
  - *What did you think was going on in such picture(s)?*
  - *Did you disagree with anything that was presented?*
  - *If so, what did you see that was different?*
- Each small group will be asked to identify 5-8 pictures to share with the broader group in the larger dialogue. Decision making on prioritizing pictures will be guided by a facilitated, nominal group process.

- Arrange the pictures identified by participants so that they are visible to all group members and remove those pictures that were not highlighted by one or more participants.
- Tell each participant that she is given three votes; ask each participant to choose the top three photos from this group that stand out most in terms of how they affect health in Hartford.
- Go around the group and ask each participant to identify his/her 3 top choices.
- As participants are reporting their choices, list all picture #s on flip chart.
- Tally up the results.
  - The 3 pictures with the highest tally will be submitted for larger group discussion. In the case of a tie in rankings from one through five, all photos which tied for any such place will be included in submission to the larger group discussion.
- Ask group members to matte their identified pictures on flip chart paper. (Please post one picture per flip chart page.) Together, ask them to briefly summarize why they chose the picture, what they see happening here, what may be really happening, how it relates to our lives, why the problem or strength exists, and what can we do about it. One group member or you as the facilitator should note this under each picture.
- Each group should identify one reporter who will be responsible for sharing their photos with the larger group.
- Once complete, please give flip chart pages to Karen. Your group is now ready to participate in the large group dialogue. Please give participants a brief break (as per timeline).
- At the end of the small group session, please collect all completed ShOWED worksheets.
- On “Small Group Facilitator Memo” worksheet, please note briefly how the experience was facilitating the small group; did anything stand out to as remarkable or noteworthy? Please reflect on the level of participation of your group members, any challenges that arose, and any highlights that you recall.

### **Large Group Facilitation**

- Everyone will regroup together in the HHC auditorium.
  - Karen will review ground rules for large group discussion:
    - Confidentiality
    - Respect—It’s OK to disagree, but try to use “I” statements and speak for yourself.
    - One person speaks at a time.
    - Step Up...Step Back
    - \_\_\_\_\_
    - \_\_\_\_\_
- Participants will be invited to add ground rules and everyone will be asked to agree to ground rules before moving forward. (These will be saved to also be used in second critical dialogue in Stage IV).
- The reporter from each group will be asked to share the group’s photos with the larger audience. (Each group will be given 5 minutes).



- Once all groups have presented, large group questions may include:
  - What are some of the overarching themes that came up today?
  - What points most stood out to you?
  - What are the most pressing health-related challenges facing Hartford?
  - What are some of the reasons for these challenges?
- Participants will be reminded that in our next dialogue, we will identify one to three major themes in which to prioritize in the action phase of this project. Thus, moving forward, participants will be asked to think about what these priorities might be and to bring any ideas to our next meeting. They also will be asked to consider what might be done to address these concerns.
- Participants will be thanked for their time and incentives will be distributed.

## Appendix L: SHOWED Mnemonic Free Write



**Health in Hartford Study: First Critical Dialogue  
ShOWED Free-Write**

Participant Identification #: \_\_\_\_\_  
Group Name: \_\_\_\_\_

Picture #: \_\_\_\_\_

**1.) What do you SEE here?**

---

---

---

---

**2.) What's really HAPPENING here?**

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---

**3.) How does this relate to OUR lives?**

---

---

---

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**4.) Why does this problem, concern, or strength EXIST?**

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**5.) What can we DO about it?**

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## Appendix M: Small Group Facilitator Memo



## Health in Hartford Study: First Critical Dialogue Small Group Facilitator Memo

**Group Color:** \_\_\_\_\_

Please note below how the experience was facilitating your small group. Did anything stand out to as remarkable or noteworthy? Please reflect on the level of participation of your group members, any highlights you call, and/or any challenges that arose.

This image shows a full page of blank white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for writing or drawing. There are no margins, text, or other markings present.

Health in Hartford Photovoice Study

# Facilitator's Guide Second Critical Dialogue

Stage IV

March 5, 2016

**Lead Facilitator:** Karen D'Angelo, MSW

**Small Group Facilitators:** Doctoral students and recent graduates from UConn School of Social Work, along with undergraduates from UConn, will be small group facilitators; all will have received CITI certification documenting that they have received training in human subjects social and behavioral research.

Facilitator Contact Information:

Name	Email	Cell
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX
XXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	(XXX)XXX-XXXX

**Participants:** Health in Hartford Photovoice Study Participants (n=17)

**Date:** March 5, 2016

**Meeting Time:** 9:00am

**Start Time:** 9:30am

**Location:** Hispanic Health Council, 175 Main Street, Hartford, Connecticut

**Goal:** The goal is to make Hartford a healthier place to live. The objectives of this study are to 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy; and 3.) Develop an action plan to share the findings of this study.

**In this fourth phase of the Health in Hartford study, participants will review the key concerns identified in Stage III and brainstorm possible solutions to these areas. Participants will then identify priority areas for change in Hartford. Participants will also reflect on their sense of collective efficacy and any changes to their perceptions of collective efficacy that may have occurred during the course of this study.**

**Resources:**

- PowerPoint slides
- Flip Chart notes with photos from Stage III posted on wall of HHC auditorium
- Blank flip chart paper for "Parking Lot" posted on wall of HHC auditorium
- Flip chart with ground rules listed on them from Stage III
- Laptop
- Projector

- Markers
- Flip chart paper for brainstorm—2 sheets per each theme (16 total pages)
- Pens (1 per participant; 17 total)
- Copies of Collective Efficacy Post-Test (1 per participant; 17 total)
- Copies of informed consent for dissemination of findings (17 total)
- Note pad for note takers (2 total)
- Digital recorders (3 total)
- Table and chairs set up in U shape
- Copies of resource list to distribute to all participants (17 total)
- Copies of original informed consent form for study available upon request
- Food
- \$20 in an envelope for each participant (17 total)
- Sign in list

**Timeline: Start at 9:30am**

Minutes	Time	Activity	“Staff”	PowerPoint Slides & Forms
15 min.	9:45	-Participants will arrive at Hispanic Health Council. -Participants will be checked-in and invited to take food. -Participants will be asked to assemble in the auditorium and to review the flip chart notes from Stage III	-Student(s) will greet participants, sign participants in, verify contact information and distribute name tags with participant ID #s	Slide 2
5 min	9:50	-Reorientation to study; review objectives and ground rules	-Karen as lead facilitator -Jack as co-facilitator -Notetakers	Slides 3-4
10 min	10:00	-Review comprehensive list of key points identified in Stage III (These are themes developed by Karen based on participants’ flip chart notes and large group discussion) -Ask participants if at first glance, these make sense or if there is anything missing from or out of place with this list. Record any initial feedback from participants, and table any additional suggestions in the “Parking Lot.” -This process may be repeated as the discussion evolves	-Karen as lead facilitator -Jack as co-facilitator -Notetakers	Slide 5
60 min	11:00	-Review each key point in depth, providing a summary of what was discussed in Stage III and prompting for suggested solutions. -Brainstorm solutions to the priorities identified	-Karen and Jack -Notetakers	Slides 6-13
10 min	11:10	Break		
10 min	11:20	-Administer Collective Efficacy post-test in group format	-Karen and staff	Slides 14-16 CE Post-Test
15 min	11:35	-Qualitatively assess perceptions of collective efficacy	-Karen and Jack	
10 min	11:45	-Wrap up and conclusions	-Karen	
10 min	11:55	-Administer final consent form	-Karen and staff	Slide 17 Consent Form
5 min	12:00	-Collect consent forms and distribute cash acknowledgements	-Karen and staff	Slide 18 \$20/participant

Once participants arrive at the Second Critical Dialogue, a student will escort them to the HHC auditorium and ask them to independently review the flip chart pages from Stage III that will be displayed on the walls. They will also be asked to reflect on the following questions (posted on PowerPoint presentation, slide 2):

- 1.) What are some of the overarching themes that came up in Stage III?
- 2.) What points most stood out to you?
- 3.) What are the most pressing health-related challenges facing Hartford?
- 4.) What are some of the reasons for these challenges?

After most participants have a chance to review the flip charts, the formal community dialogue will begin. Notetakers should also begin taking notes. Remind participants that this is the second critical dialogue and the fourth phase of the Health in Hartford project.

- The main objectives of this study are to: 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy; and 3.) Develop an action plan to share the findings of this study with the broader goal of making Hartford a healthier place to live.
- The goal of this dialogue is to review the main concerns that you have identified in Stage III and to brainstorm solutions to those concerns. These suggestions will be shared with the broader community in an effort to promote change in our city that will make Hartford a healthier and even better place to live.
- These ground rules are used to guide our group process. They were developed in our last session, at Stage III of this study.
  - Confidentiality – let's agree to not share anything that anyone says outside of this room; that way we create a safe space for people to openly talk.
  - Respect – It's OK to disagree but try to use "I" statements and speak for yourself
  - One person speaks at a time
  - Step Up...Step Back: If you are someone that has said a lot and you feel that you may be dominating the conversation a bit, please try to take a step back to create space for others to share. Alternatively, if you are someone who has not said much, please try to take a step up and participate – we are all going to learn best by everyone's participation.

Invite participants to add any ground rules that may be missing; note these on the Flip Chart list of ground rules.

- \_\_\_\_\_
- \_\_\_\_\_

Ask if all participants agree to these ground rules. Make eye contact with all participants to confirm. Note that the guidelines are hanging on the flip chart paper in case we need them as a reference.

- Remind participants of the following:
  - Confidentiality is very important. Thus, as in previous stages of this project, we are using our assigned numbers instead of names, so that we can keep our discussions as anonymous as possible. It is important that as you share, your number is identified for the purposes of recording the conversation.



- Because we are talking about concerns regarding the places in which we live, we may experience emotional reactions or become upset. If you are upset, you are welcome to take a break at any time. Also, if you need to talk with someone, please let Karen know. Karen has a list of resources (that were given to each of you when you attended the focus group or when you signed-up for the study) that are being distributed just as an extra reference, in case it's helpful.
- Participation is completely voluntary and you are free to leave at any time without any negative consequence. However, only those who stay for the entire dialogue (no more than 3 hours) will be entitled to the \$20 compensation at the end.

Tell participants that the formal critical dialogue will now begin. Turn on all digital recorders.

To initiate critical dialogue, review the Key Points that are summarized on slide 5.

- Access to Healthy Food
- Litter
- Community Investment
- Access to Nature
- Housing & Homelessness
- Education & Role Models for Young People
- Substance Abuse
- Community Engagement

Note that this list was compiled by the group discussion and notes from Stage III, and the pictures chosen in Stage III. Ask participants:

- “As you look at this list, does it make sense to you? Do you think anything is missing from this list? Do you suggest that we change anything about this list?”
- Process suggestions from participants with the group. Document any suggested changes in the Parking Lot.
- Highlight that as we delve into each of these in more depth, if you have questions, please share these with the group.

Review each key point in more depth by reading aloud the summary. Note that this summary that I read from each group refers to the pictures highlighted in the slide and includes only the discussion points presented by each group in our last meeting. *Highlight that these are the perspectives from this group as they were presented in our last meeting. I am simply summarizing what was previously discussed.* Process each with the group, with the noted prompts:

- **Access to Healthy Food**  
*Four groups highlighted food access as a major concern. Three of these pictures involve community gardens, which are “cost effective” and enable community members to grow healthy produce. The Hartford Mobile Market is an example of a community strength—it sells produce in the community and is very visible. “We are what we eat” and we need to make healthy choices with regards to our diets, such as incorporating vegetables into our meals. Diabetes is a major health concern in our community—it has many complications and many sources, including dietary habits. Education about growing food is important, and perhaps community members who grow food can sell it*

to their neighbors. This grocery store in this picture has closed down; this has meant less access to healthy food for Hartford residents. We need to speak up about this concern.

- **Litter**

Four groups identified litter as a health-related concern that is commonly found in Hartford. General consensus was that litter is a health hazard—examples included its danger for children who may put trash in their mouths, its impact on air quality, and bedbugs, which may be embarrassing and a health hazard. People need to take more responsibility in disposing of litter. Trash collection systems need to be improved; trash bins need to be larger, trash pick-up may need to occur more often, and/or public works programs such as mattress removal need to be more visible.

- **Community Investment**

Four groups highlighted community investment as a key priority in Hartford. Empty, overgrown lots are common; they are lost opportunities for productive use of public space. New projects were highlighted with the photos of the development projects. Stark distinctions were emphasized, as in the sidewalk photo that is in contrast to the recent investment made to Nelson Court. Landlord accountability was highlighted in the building with maintenance happening to the physical infrastructure. The CT Science Center was seen as a strength because it “brings people to our town.” Investment needs to happen in ways that benefit the community, such as revamping abandoned apartment buildings into affordable housing units. The last picture is a “Double Plus” because it highlights the investment in the road infrastructure, as well as the addition of the new women’s shelter—this area has seen a lot of improvement. In sum, community investment was seen positively, and several strengths were highlighted; at the same time, some areas were identified as needing additional investment, including better physical infrastructure and more social programming.

- **Access to Nature**

Two groups emphasized the importance of nature and its positive impact on health. The photo of the baby in the garden highlighted the fact that this toddler was able to experience the garden using all his senses. The garden provides an opportunity to grow food. The picture of the flowers highlights how gardens are “relaxing for people” and provide a chance for meditation. Finally the waterfall picture shows a peaceful and quiet environment, which promotes the enjoyment of open spaces. Opportunities to interact with nature were seen as important to creating a healthy environment.

- **Housing & Homelessness**

Housing and homelessness were common concerns regarding health in Hartford, as it was highlighted by three groups. Homelessness was seen as an epidemic, due to a broken system. The many abandoned buildings in Hartford, as depicted here, are opportunities to create affordable housing. Abandoned properties create more urgent health challenges because they pose threats to people who may be seeking a temporary place to stay, inside of them. The women’s shelter was highlighted as an important support for women and children.

- **Education & Role Models for Young People**

*Educational opportunities and role models for young people emerged as a priority in three groups. This first picture shows young people looking on as two men box; the admiration and respect these children have emphasize the power and influence we adults have on young people. We need to create more opportunities for mentorship and positive role models. The Parker Memorial Community Center was highlighted as a safe place for families to visit; it promotes learning and a place for youth to go to stay off the street. In the picture of the baby in the garden, it was emphasized that small things make a big difference—by introducing this child to gardening, he is learning about nature and food. Finally, the CT Science Center was emphasized as a place that provides education for children.*

- **Substance Abuse**

*Drugs and alcohol were identified by three groups as serious health challenges for Hartford residents. People are seen hanging out next to advertisements for alcohol—highlighting how pervasive substance abuse is in the community. Evidence of these challenges is seen in the litter on the street, as well as in the homelessness epidemic. This community in the center was described as “drug infested,” suggesting that the community here struggles with addiction and drug activity. Graffiti art, which is common in the city, may be used to convey meaningful messages such as “Say No to Drugs,” as long as there is permission granted by property owners.*

- **Community Engagement**

*Community engagement was identified by four groups as a key priority regarding health in Hartford. Men are shown here, hanging out on the street, suggesting that they are not working, or attending a “program.” These folks need to be engaged in productive activities. This is a downtown space that is well utilized for the public good; it’s a popular community gathering spot and even provides sprinklers for children in the summer. The baby in the garden was highlighted as an example of “community involvement” in this garden project. This community mural is an example of public art that depicts unity; it represents where our city should be going. Parker Memorial Community Center is a place that fosters valuable community engagement by providing opportunities for exercise and social interaction, for every age, that are free and local. Graffiti art in the city is often an example of great talent, though some is hard to read. There is an opportunity here to engage artists in promoting meaningful messages through their art.*

-Review each key point in depth, providing a summary of what was discussed in Stage III and prompting for suggested solutions.

-Prompt participants to deeply analyze suggestions in order to promote a critical discussion about ways to improve health in Hartford.

*Break: Provide participants with a ten minute break.*

-Distribute Collective Efficacy Scale to all participants, along with pens. Explain that this survey may seem familiar because everyone took it at the beginning of the study. These questions refer to the neighborhoods in which you live. Note: Please follow along as I read each question aloud; please do not skip ahead. I will be using a visual on the slides (PowerPoint slides 15-16) to help illustrate the response options for each question.

If you have questions, a staff member will be happy to assist you. Administer collective efficacy scale and collected completed responses.

-Qualitatively assess perceptions of collective efficacy using the following questions:

- 1.) *Thinking about the neighborhood in which you live, do you think that the people who live in your community have a shared sense of responsibility of what happens in your neighborhood? Why or Why not?*
  - a. *Do people have a shared understanding of what to do if something goes wrong?*
    - i. *For example, can you count on your neighbors to take action if they witnessed children skipping school and hanging out on the street corner?*
  - b. *Can you count on your neighbors to take action if something threatens the safety of people in your neighborhood?*
    - i. *For example, if the budget for the local fire department becomes threatened, do you trust that your neighbors would come together to stop its closure?*
- 2.) *Do you think that people who live in your community are close? Why or why not?*
  - a. *Do neighbors share the same values? Can you provide an example?*
  - b. *Are people willing to help each other in your neighborhood? If so how? If not, why do you think this is the case?*
- 3.) *Can you think of any examples of how people in your community are working together to make it a better place to live?*
- 4.) *Since the start of this study about a year ago, did you notice any changes in your perceptions of how engaged your neighbors are in helping each other? Did you notice any changes in how much you trust your neighbors?*

-Wrap up and conclusions

- Ask participants if they have any final comments that they'd like to share. What will they take away from participating in this research project? What are their reflections on this experience? Did anything about this process surprise them? If so, what? How? Do they have any suggestions for what they'd like to have been done differently if they were to participate in a process like this again?
- Do they have any suggestions for who to share the findings of this study with?

-Administer final consent form. Explain that the formal research process is now over. Our next step is to share what we learned here with others. Participants may choose to continue to remain anonymous with regards to this study. Alternatively, they may instead wish to have their names identified with this project. If they'd like to have their names associated with this project, they

may also decide if they'd like to be part of the process of developing the Action Plan report or presentations, and or sharing these with others in the community. If at any time, participants decided that they'd like to change their minds regarding this decision, they may contact me and change their preferences at any time. In which case, they will need to complete another Informed Consent Form: Dissemination. Additionally, the final Action Plan report will be made available to all participants who request a copy; please contact Karen in July 2016 to request one if you are interested.

-Thank participants for their participation. Collect signed consent forms and distribute cash acknowledgement (\$20 per person)

## Appendix O: Stage IV Presentation

# Health in Hartford!

## A Photovoice Project

### Stage IV: Second Critical Dialogue



K. D'Angelo  
March 5, 2016



## Reflection Questions

As you review the photos and the notes presented by each group at the First Critical Dialogue, please reflect on the following questions:

- What are some of the overarching themes that came up in Stage III?
- What points most stood out to you?
- What are the most pressing health-related challenges facing Hartford?
- What are some of the reasons for these challenges?
- What are some changes you'd like to see in Hartford, that would make this city a healthier place to live?

## Welcome Back!

- Thanks for joining us!
- This is the 4<sup>th</sup> and final part of a 4-stage research project.
- Today, as a big group, we will:
  - Review the pictures and priorities highlighted in Stage III
  - Brainstorm possible solutions
  - Reflect on the neighborhoods in which we live
- You will also be asked to take part in a brief survey, similar to the one you took at the beginning of the study.
- Next Steps—What will we do with all this information from the Health in Hartford study?

## Ground Rules

- Confidentiality
- Respect
- One person speaks at a time
- Turn off cell phones to remove distractions
- Step Up...Step Back—We want to hear from everyone!



## Summary of Key Points

- Access to Healthy Food
- Litter
- Community Investment
- Access to Nature
- Housing & Homelessness
- Education & Role Models for Young People
- Substance Abuse
- Community Engagement

## Access to Healthy Food





# Litter



# Community Investment





## Access to Nature



## Housing & Homelessness





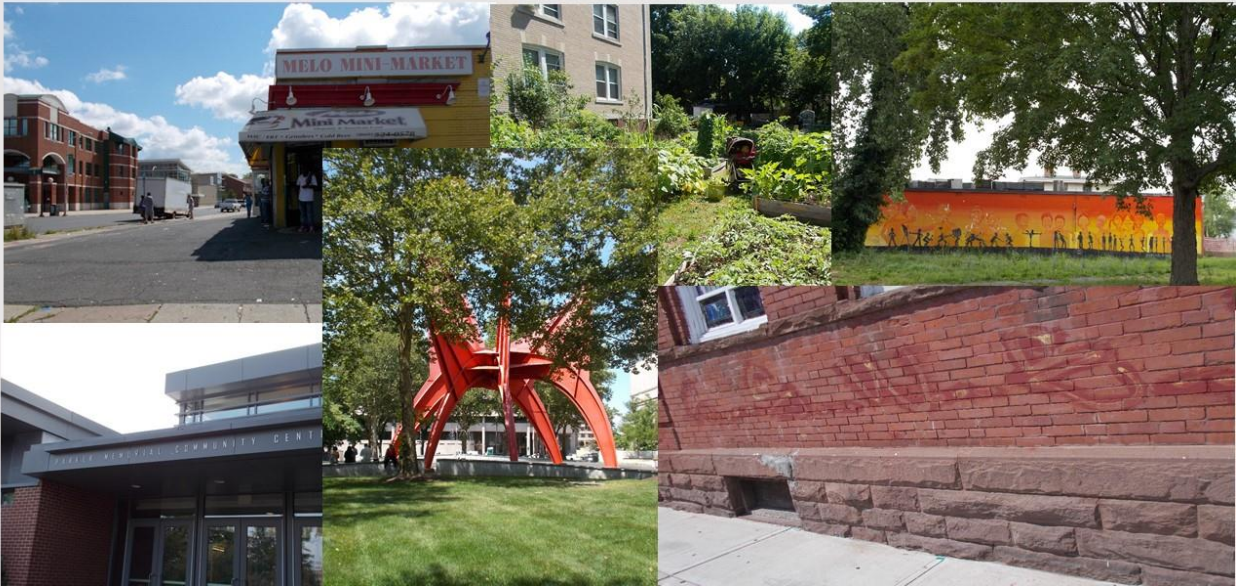
# Education & Role Models For Young People



# Substance Abuse



# Community Engagement



BREAK

## Collective Efficacy Scale Survey

- This survey is the same as some of the questions you were asked at the beginning of the study.
- Please note your ID number and today's date at the top of the page.
- As I read each question aloud, please circle the answer that best represents your perspective. An image will be displayed on the slide to help you visualize the scales.
- If you need assistance, please do not hesitate to ask and one of us research staff will be happy to assist you.

HHH Appendix IIIA Cue Cards for Collective Efficacy Scale

**"Very  
Unlikely"**



**"Somewhat  
Unlikely"**



**"Neither  
Likely Nor  
UnLikely"**

**"Somewhat  
Likely"**

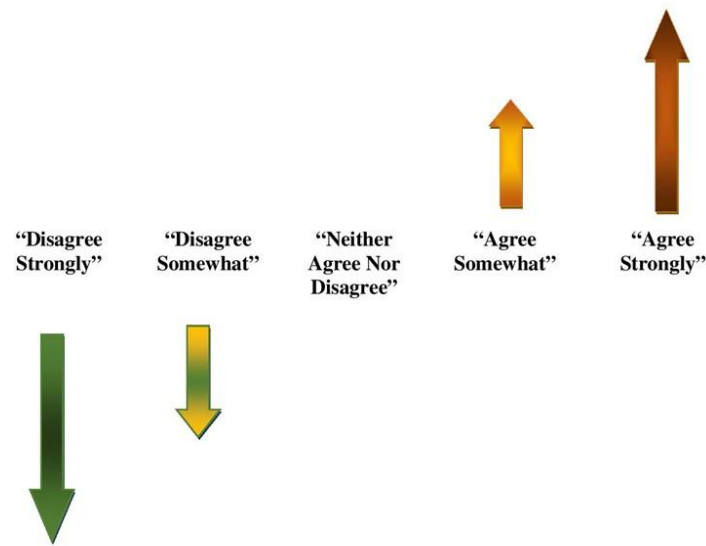


**"Very  
Likely"**



Question 1





Questions 2-6

## Next Steps

- The data collection stage has ended and this research project is now over. We will now prepare to share what we have learned from this study with the broader community. It is our hope that by doing so, we may help to make Hartford a healthier place to live.
- You have a couple of voluntary choices about your involvement in the process to share the findings of this study with others:
  - You may choose to keep your identity confidential, and thus not have anyone outside of this study know of your involvement with this project.
- OR
- You may choose to have your name attached to reports or presentations that will publically share the results of this project.
  - If you choose this option, you may also decide if you would like to be part of the process of sharing the findings of this study with others. In this case, you may be invited to help create presentations and/or reports and/or to share these products with others.
- Please review, complete, and sign the form:
  - **“Stage IV Informed Consent Form: Dissemination of Findings”**
- Anyone who wants a copy of the Action Plan may contact me in July 2016. Anyone who requests a copy will be provided with one.

# Thank You!

- Thank you for taking part in this research project.
- Please hand in your completed form.
- Receive your \$20 cash acknowledgement from Karen before you leave.

## Appendix P: Collective Efficacy Post-Test

1

**Collective Efficacy Scale**

Participant ID: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for participating in this study. The primary objectives of this project are to: 1.) Learn about how residents of Hartford perceive the place that they live and its impact on the community's health; 2.) Identify ways to improve the living conditions in Hartford in order to make it more healthy; and 3.) Develop an action plan to share the findings of our study with the broader goal of making Hartford a healthier place to live.

The questions below are a follow-up to the initial survey you took at the beginning of this study. As a reminder, all information that you share is stored by participant ID number only, not by name, and all data is kept confidential. I am the only person who will have a record of your ID number and this record will be kept in a locked storage cabinet and destroyed at the end of the study. If you have any questions about this survey, please do not hesitate to ask.

*I will read each question aloud to the group and show you a visual that may help you answer these questions. Please follow along with me and do not skip ahead.*

The following questions ask you to think about the residents in the neighborhood in which you live. Please circle one response for each question. You may refer to the visual cue cards as a reference.

1.) How **LIKELY** is it that your **NEIGHBORS COULD BE COUNTED ON** to **TAKE ACTION** if:

a. **Children were skipping school and hanging out on a street corner?**

1	2	3	4	5
Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely

b. **Children were spray-painting graffiti on a local building?**

1	2	3	4	5
Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely

c. **Children were showing disrespect to an adult?**

1	2	3	4	5
Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely



**d. A fight broke out in front of their house?**

1	2	3	4	5
Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely

**e. The fire station closest to home was threatened with budget cuts?**

1	2	3	4	5
Very Unlikely	Somewhat Unlikely	Neither Likely Nor Unlikely	Somewhat Likely	Very Likely

Next, please tell us how much you AGREE with each of the following statements.  
Please circle one response for each question.

**2.) People around here are willing to help their neighbors.**

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly

**3.) This is a close-knit neighborhood.**

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly

**4.) People in this neighborhood can be trusted.**

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly

**5.) People in this neighborhood generally don't get along with each other.**

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly

**6.) People in this neighborhood do not share the same values.**

1	2	3	4	5
Disagree Strongly	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Agree Strongly

**7.) Please tell us what zip code you currently live in:**

My current zip code is \_\_\_\_\_

## Appendix Q: Dissemination Informed Consent Form



### Informed Consent Form: Dissemination Health in Hartford: A Photovoice Project

As you are aware from the informed consent form that you signed at the start of this project, Health in Hartford is a research study. It is your right as a participant of this study to have your confidentiality protected.

One of the goals of this study is to share what we have learned with people who may help us create change in Hartford and make it a healthier place to live. Though this research project is now formally over, reports and presentations are going to be made with the goal of sharing the findings with others.

Since you helped to create the photos and findings from this study, rather than keeping your identity private, you may instead prefer to share your identity as a participant of this project. If you choose to have your identity shared with regards to this study, your name may appear on reports or presentations that aim to inform others about the findings of the study. You may also be invited to help present this information. Your participation is completely voluntary, and there will be no cash acknowledgment if you choose to share your identity, nor if you choose to help share the findings.

**Please choose whether or not you would prefer to maintain confidentiality with regard to your participation in this study. Your decision is completely up to you. No matter what you choose, your decision will be respected. And, no matter what you decide, there will be no penalty. If you do not complete this form, it is assumed that you prefer to have your identity remain confidential. Please check the box below that represents your wishes:**

- ☐ **I choose to NOT have my name attached any reports or presentations.** (Presentations may include, but are not limited to the following places: City Council Meeting, local community advocacy group, Hartford Public Library, etc.) **I do not want my identity revealed in reference to this study.** If I choose this option, the researcher will continue to make every effort to protect my confidentiality.
- ☐ **I choose to have my name attached to any reports or presentations.** (Presentations may include, but are not limited to the following places: City Council Meeting, local community advocacy group, Hartford Public Library, etc.) **My name may be included on documents that will publically share the results of this project.**

If you choose to share your identity with regard to this study, you may also decide whether or not you would like to be actively involved with the process to share findings from this study with others. In this case, you may be invited to take part in creating and/or delivering presentations or reports. If you choose to be involved with this process, please leave your contact information below. By doing so, you are giving permission to be contacted in the future in order to help share the findings of this study. Your participation in this process is completely voluntary, and you do not have to take part if you do not want to.

- ☐ **I DO NOT wish to take part in sharing the findings of this study with others.**
- ☐ **I WISH TO take part in sharing the findings of this study with others.**

My phone number is \_\_\_\_\_.

My email address is \_\_\_\_\_.

My mailing address is \_\_\_\_\_.

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**If at any point you change your mind regarding whether or not you choose to have your name connected with this study, you are welcome to contact me at any time. You will then need to complete another *Informed Consent Form: Dissemination* to note the change in your preference.**

**Action Plan:**

If you would like to receive a copy of the Action Plan, please contact me between July 1<sup>st</sup> and 31<sup>st</sup> 2016. Copies will be made available to all participants who request one.

**Questions:**

**If you have any questions about this study you can contact me, Karen D'Angelo, Student Investigator, at (860) 527-0856 X 267, or Scott Harding, Principal Investigator in charge of this study, at (860) 570-9182. If you have questions about your rights as a participant, you may call Laura Victoria Barrera, member of the Institutional Review Board of the Hispanic Health Council, at (860) 424-4892.**

**I HEREBY CERTIFY THAT I HAVE READ THIS CONSENT FORM, I UNDERSTAND ITS CONTENTS, AND THESE CHECKED BOXES INDICATE MY WISHES REGARDING MY INVOLVEMENT WITH THE PROCESS OF SHARING THE FINDINGS FROM THIS STUDY.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person  
Obtaining Consent

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date